S. Hrg. 99-920

FEDERAL INCENTIVES FOR STATE HEALTH CARE PROFESSIONAL LIABILITY REFORM ACT OF 1985

HEARINGS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

ON

S. 1804

TO PROVIDE FOR FEDERAL INCENTIVE GRANTS TO ENCOURAGE STATE HEALTH CARE PROFESSIONAL LIABILITY REFORM

MAY 7, JULY 22, AND SEPTEMBER 11, 1986

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FEDERAL INCENTIVES FOR STATE HEALTH CARE PROFESSIONAL LIABILITY REFORM ACT OF 1985

WEDNESDAY, MAY 7, 1986

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:07 a.m., in room SD-430, Dirksen Senate Office Building, Senator Orrin G. Hatch (chairman) presiding.

Present: Senators Hatch, Kennedy, Grassley, Kerry, Metzenbaum, Pell, Thurmond, Nickles, Simon, and Dodd.

OPENING STATEMENT OF SENATOR HATCH

The CHAIRMAN. We are happy to welcome you all to our committee hearing this morning which is, we think, a very important hearing.

Ladies and gentlemen, as we convene this hearing today, there is a great deal of recrimination going on as to the causes and the effects of the medical malpractice insurance crisis.

For example, the public interest groups blame the insurance companies; the doctors blame the lawyers and the insurance companies; the insurance companies blame the lawyers. The lawyers say, "What crisis?"

Frankly, I just have to say we have a crisis when the number of claims per physician has increased more than fivefold since the midseventies and when the average award has more than tripled.

I would say we have a crisis when there are 900 new malpractice suits every day. I would say we have a crisis when the average award in a malpractice case amounts to $300,000.

I would say we have a crisis when nearly a fifth of the amount spent on physicians' services is related to litigation. That does not include all of the costs to public health and health in general throughout the country caused by the fear of being sued for medical malpractice—the overexaminations, the overdiagnostic procedures, the overprognostic procedures, and so forth.

As I recall, Joe Califano on time estimated that it cost us 35 percent of all health costs because of the fear of having your reputation ruined as a result of medical malpractice lawsuits.

But I would say we have even a bigger crisis when patients lose access to quality health care—when doctors are deserting high-risk areas of their practice—when obstetricians and family practitioners will not deliver babies anymore—when clinics serving the poor and others in special need close, and when 2,500 certified nurse-midwives have been refused renewal of their insurance policies.

Even for those patients whose doctors continue in practice, health care will be less accessible because it will cost more. In addition to the passthrough of higher insurance premiums, some have estimated that the indirect cost of unnecesasry, defensive medicine should be set at a minimum of $15 billion a year. That is a lot of money.

There is no question that we have a crisis on our hands. But as to the dispute about who is causing it, all I can say is that everybody is right; there is plenty of blame to go around.

Part of the problem does lie with the insurance industry, which has punished all doctors—even doctors who have never been sued—instead of basing premiums on the degree of risk, judged by a physician's record or other, fairer underwriting practices.

Part of the problem lies with sensationalist press coverage which has conditioned the public to expect medical miracles, when miracles really are few and far between. Doctors do make honest mistakes, and all too often, these are mistaken for malpractice.

We have broadened the laws to such an extent that even though they have practiced the highest medical traditions and practices, they still can have tremendous awards made against them.

Frankly, part of the reason there is a malpractice crisis out there is because malpractice really exists.

The State of Florida recently organized a Task Force on Medical Malpractice. It was composed of representatives of all the various interest groups. This task force found that negligence or poor performance in hospitals resulting in serious injuries or death occurred in about 5 percent of the patients in that State.

Medical researchers at the University of Minnesota who studied 220 obstetric claims discovered that two-thirds of the recognized risk factors were mismanaged. Now, that is really unbelievable.

Now, I certainly do not intend to engage in any finger pointing today. In fact, if we are going to straighten these things out and preserve what we all want—that is, access to quality care for patients—we will all have to stop the finger pointing and accept our share of the blame. It may sound corny but I would like to say that this is truly one area if you are not part of the solution, you are part of the problem.

In order to begin the process of establishing a consensus, I recently introduced a proposal for Federal action on the malpractaice crisis. This legislation requires all the parties that I have mentioned to make a contribution to the solution for malpractice, just as all these parties, in my opinion, have made a contribution to the problem.

Now, the bill, S. 1804, includes development grants to States who wish to study tort reform and incentive grants to States which adopt all four of the bill's recommended reforms.

It would require States to allocate a portion of licensing fees to the State board or agency responsible for disciplining health care providers and require insurance companies to provide information on settlements and awards to these boards to help them in their deliberations. It would also require hospitals to develop risk management programs to reduce the incidence of malpractice.

I think this legislation is a good start toward the kind of consensus we need to solve this problem, and will provide a good basis for further debate. But the first step is for all of us to recognize that we do have a problem—a problem that is not being solved by current risk management techniques—and that problem is a lack of adequate insurance at reasonable premiums.

Our witnesses today will testify as to further problems being spawned by this, the most important of which is simply that patients who need care cannot get care in some areas.

We are holding this hearing to establish the fact that we do have a problem, and to bring all the parties together to see if we can take the next step; find some solutions together.

And I do not intend for the hearings to stop here or for those efforts to stop here. Our next set of hearings will focus on the insurance companies and on trial lawyers. But I do not want them to wait until they get to the witness table to participate in our effort to find a consensus. I would like them to get together with the doctors that we will be hearing from today and with us. Let us get together and let us find a solution to help the people who are really suffering: the patients we all care about so much. It is really important that we do.

At this point opening statements by Senators Thurmonds, Metzenbaum, Simon, Pell, Dodd, and the prepared statement of Senators Kerry and Grassley will be inserted in the record.

[The statements referred to follows:]

OPENING STATEMENT BY SENATOR STROM THURMOND

Senator THURMOND. Mr. Chairman, first of all, I would like to commend you for holding hearings on this very complex and important issue. I have heard from many with diverse views regarding this issue of national scope. In addressing this problem any solution fashioned—whether by State legislatures or by Congress—must consider the views of all parties affected by medical malpractice. Therefore, I feel these hearings are timely, and will be helpful in identifying the problems associated with this issue.

Health care providers, the insurance industry, lawyers, and victims of medical malpractice, each have their own point of view, not only of the causes of the problems, but also of its scope.

The health care community is concerned about the increasing cost of health care resulting from medical malpractice law suits, which ultimately must be passed on to the public. Physicians are concerned about having to practice "defensive medicine," where they must order tests, not normally needed, to avoid potential criticism in the event of an unsatisfactory result. The American Medical Association estimates that an additional $15 billion a year is added to the cost of health care because of this practice. Another cost associated with medical malpractice is the payment by physicians of over $4 billion a year in professional liability insurance. Doctors are also concerned about the increasing prospects of a long drawn out malpractice trial, and its effect on their practice and family life, even if they are exonerated—as they are 75 percent of the time.

The concerns of the insurance industry must also be addressed. The industry has pointed out that in 1984 it suffered an underwriting loss on policies of more than $20 billion. In addition, some would say that sypathetic juries, overwhelmed by persuasive lawyers, have awarded undeserved millions of dollars in damages. Insurance spokespersons cite figures from studies which indicate an average award in malpractice cases of $950,000, and 360 verdicts in 1983 of more than $8 million.

In addition to the views of health care providers and the insurance industry, the legal profession has expressed its concerns. Lawyers have cautioned against interference with the jury process. Reminding us of our cherished right to a jury trial handed down since Magna Carta, the legal profession has pointed ot that the jury has been the counterweight to the arrogance, prejudice, tyranny, ignorance, and plain dishonesty of abusive governments, and the rich and powerful. Any proposed restraints on the jury process should be closely examined.

Attorneys have also cited a major new study of court filings in 25 States by the National Center for State Courts. According to the report, in most courts surveyed, litigation actually declined between 1981 and 1984. In addition, in my home State of South Carolina, the Trial Lawyers Association concluded from its study that the average malpractice claim amounted to approximately $8,000.

Finally, as we examine all the issues associated with medical malpractice, we must not forget the rights of malpractice victims. Unfortunately, and despite the fact that America has the best health care in the world, malpractice does occur. We must ensure that victims suffering from negligent care causing such conditions as permanent paralysis, permanent brain damage, or any number of medical problems are fairly compensated.

Thus, medical malpractice poses complex and difficult problems. It is my hope that this hearing will shed some light into this area, and help to show how best to balance these various competing interests.

I regret that other duties of the Senate require that I leave at this time, but I look forward to reviewing the testimony presented today.

OPENING STATEMENT BY SENATOR HOWARD METZENBAUM

Senator **METZENBAUM**. Mr. Chairman, the medical malpractice crisis has hit the headlines. Doctors descend on State capitols to protest skyrocketing rates; the insurance industry want to perform major surgery on the Nation's tort system; the lawyers plead the status quo; and consumers of health care stand by in confusion—if not disbelief.

It is a divisive, emotional issue. In Detroit, a nationwide computer list allows doctors to zero in on patients who have sued in the past. In Los Angeles, the tables are turned—consumers call a hotline targeting doctors who have been sued for malpractice.

We are told malpractice premiums cost the profession $2 billion a year; that they have added $250 to the cost of having a baby; a $1,000 to the cost of neurosurgery; $20 to a doctor's visit. The price of so-called defensive medicine—where doctors perform additional tests et cetera to protect themselves from being sued—is placed somewhere between $15 and $40 billion a year.

There is obviously a problem; the question is how best to find a solution. The search is complicated by the players—and stakes—involved.

I cannot remember an issue with so many important professional interests at stake. You've got the doctors, the lawyers, the hospitals, and the insurance industry. The medical malpractice/product liability issue has become the superbowl of high-powered lobbying.

My concern is that the consumer may get lost in the crunch. After all, they are the big losers when health care services become more costly and less available. We cannot for a minute forget about the consumers who fall victim to malpractice in this country. There are an estimated 130,000 such victims each year. Let's not lose sight of how we would feel if it were our child, our spouse, or our parent.

Mr. Chairman, I must confess my concern is heightened by the witness list for today's hearing. Of 18 witnesses, 13 are medical professionals or representatives of medical organizations. I am certain they all have an important point of view. But so too do the victims of malpractice and it is their point of view which unfortunately will not be heard by the committee today. I certainly hope we can include such testimony at our next hearing on this issue in order that the record will show a more balanced approach.

Finally, Mr. Chairman, I would like to proffer some advice to the medical establishment here today. I honestly believe that you are the victims of this crisis. When you are being asked to bear 100- to 400-percent increases in your insurance while our own General Accounting Office states that a premium rate increase of 20 percent would have put the medical malpractice line at a break-even point, then this Congress needs to look at the way insurance companies do business—especially their antitrust exemption under McCarran-Ferguson.

So, gentlemen, don't come to Congress simply with a plan to restrict the legal rights of malpractice victims. Come to us with your support for systematic changes in the insurance industry as well as a plan to remove that small percentage of medical professionals who are at the core of the malpractice problem. Then we can take the steps necessary to solve this crisis.

OPENING STATEMENT BY SENATOR PAUL SIMON

Senator SIMON. Mr. Chairman, I am pleased to join you today for this first hearing on medical malpractice. Liability insurance has become vital to the smooth functioning of the American economy. I have heard from many health care providers about the high cost and increasing unavailability of liability insurance. The impact of this crisis affects the health care profession's ability to provide quality care and limits consumer access to health care.

I am particularly pleased to have Mr. George O'Neill, Jr., executive director, Shawnee Health Service & Development Corp., Murphysboro, IL, as one of our witnesses today. The Shawnee Health Service Corp. oversees the administration of several rural health clinics in southern Illinois. These clinics have been exemplary in serving the low-income and Medicare populations of 13 rural counties. The clinics provide services to not only young families, but also to the elderly.

The Shawnee Health Service Corp. recently received the Administration on Aging's project health award for developing a model health promotion program for senior citizens. The health centers have extended the Black Lung Clinic Program and Hypertension Control Program to many in the community. The mental health linkages initiative added mental health counselors, enabling the chronic and terminally ill, the isolated elderly and their families to receive counseling and advocacy. One of Shawnee's most recent projects is to train home health nurses in oral screening, identify and promote dental resources, and develop home-based dental services for all rural residents with limited access to such services.

I believe that services such as those mentioned are critical for the health and well-being of our citizens. Shawnee is playing an important role in providing necessary health care services to an underserved population. I am convinced that we must act swiftly to resolve the present liability insurance crisis and to prevent consumers such as those who use Shawnee Health Corp. from losing their access to neccessary health care services.

I want to thank Dr. Terry Mason, current president of the Cook County Physicians Association, who also is appearing before the committee today. I appreciate Dr. Mason sharing his experiences about how the liability crisis has not only affected his practice of pediatrics, but also how the crisis is affecting an oftentimes underserved population in the inner city of Chicago.

I look forward to hearing the testimony of Mr. O'Neill, Dr. Mason, and our other witnesses.

OPENING STATEMENT OF SENATOR CLAIBORNE PELL

Senator PELL. The medical liability crisis, as one of the most imortant issues before the Labor and Human Resources Committee during this session of Congress, is a problem which has greatly concerned me.

In the past few months, I have met with a number of physicians from my home State of Rhode Island to discuss ways in which we might alleviate the growing crisis. In the course of our discussions, these doctors have informed me that Rhode Island has experienced a 102-percent increase in physician medical liability insurance premiums in the last 3 years. Hospitals in Rhode Island have likewise been submitted to a 219-percent increase in medical liability insurance premiums from 1984 through 1986. Many doctors and hospitals are straining their resources to the limit to afford these exorbitant premium rates.

Naturally, such a deplorable state of affairs has had an inexorably deleterious effect on the quality of health care services that have been provided throughout the Nation. For instance, physicians tell me that they are losing their enthusiasm for practicing medicine, a disaffection that in some way will affect the care everyone of us receives. The pervasive malaise which now characterizes the practice of medicine may be further evidenced through the advent of defensive medicine, the flight of young doctors from riskier lines of practice and services that charge to screen both doctors and patients from each other. Some would attribute the problem to lawyers, or insurance carriers, or bad doctors, or to the public's expectation of perfection. However, we have learned, in the course of hearings regarding S. 1804, the Professional Liability Reform Act, that this is a multifaceted problem and no one group is solely to blame. Whatever the causes, it is clear that the current state of affairs is unsatisfactory and must be reversed.

In my view, S. 1804 will provide the necessary vehicle to begin the desired reversal. S. 1804 would do so by encouraging States to adopt tort reforms, require risk management programs by insurance companies, and improve the functioning of State disciplinary boards. All of these, if adopted, would positively impact on the liability problem. While there are no easy solutions, I believe that S. 1804 will, in the final analysis, be essential if we are to restore the vigor of the health care system and enhance the quality of services for all Americans.

OPENING STATEMENT BY SENATOR CHRISTOPHER J. DODD

Senator DODD. Mr. Chairman, I commend you and the committee staff for organizing the hearing this morning to explore the growing problem all segments of our communities are facing over the affordability and availability of medical malpractice insurance. I look forward not only to the testimony of today's witnesses, but also to the witness who will appear at the second part of the hearing scheduled in the near future. Because this issue affects a number of different groups, including providers, insurers, attorneys, and victims of malpractice themselves, this committee can only benefit from hearing testimony from all concerned.

Concern over this issue is not limited to any group or one locale. A Connecticut paper reported last fall that a Hartford hospital experiencing a 75-percent medical malpractice premium increase will add $5 a day to the average patient's hospital bill. A Bristol Hospital's malpractice premium, which jumped from $250,000 last year to $1.2 million this year, will represent more than 2 percent of the hospital's annual budget. Clearly, any legislative initiative which is undertaken in this area must recognize the community of intreest that both providers and consumers have in finding an equitable and efficient solution.

Some months ago, when I examined these issues in the products liability area, I found that the tort system is, in fact, a very poor compensation system. It fails to pay a significant number of people we would all consider worthy of compensation; it grossly overpays people with small losses and sadly underpays those with the most serious losses; and it simply takes too long to pay the people it does pay. Because of its uncertainty and unpredictability, it is also of quesitonable value in deterring the production of the very products causing most of the injuries. Because of these things, I introduced a product liability amendment which I believe would give the innocent victim a speedy and far more certain system of compensation for economic losses.

The failings of the tort system which I observed in the products liability context may likewise be resulting in wholly inadequate and inefficient compensation for victims of malpractice by health care providers. While a legislative solution seems appropriate, I have reservations about the approach taken by the chairman and others which simply attempts to limit the amount of recovery for noneconmic loss and attorneys fees under the tort system. I question the wisdom or fairness of any system which restricts the amount a victim of malpractice may receive without offering that victim something in return.

A more equitable solution, it seems to me, may be one patterned after the vaccine compensation bill that you, Mr. Chairman, and I others are working so hard on. I think all parties would be served best by a bill that places some limitations on tort recoveries while it, at the same time, increases the likelihood that some adequate level of compensation will in fact be paid to the victims. I look forward to any constructive comments our witnesses may have concerning a similar approach in this context.

Once again, Mr. Chairman, I commend you not only for this morning's hearings, but for your attempt to address this problem which affects us all.

John F. Kerry

Statement of Senator Kerry
July 22, 1986

MR. CHAIRMAN - I welcome the opportunity today to address the issue of medical malpractice -- an issue of overriding importance and of crisis proportions in Massachusetts, as well as nationwide. Although this problem is steeped in emotion and in few hard facts, the reality remains that skyrocketing malpractice premiums and the fear of lawsuits are affecting the cost, quality and delivery of health care. This is the second of two hearings and I look forward to listening to today's distinguished panelists address the malpractice consequences for the victims, lawyers, and the insurance industry.

The crisis in medical malpractice leaves us with many difficult decisions but no clear direction as to what these decisions should be. While we want to assure accessible and affordable health care, it is equally important that we maintain a fair, responsible and prompt system for compensating victims of malpractice. In addition, the malpractice dilemma is by no means limited to the medical profession.

Day care providers, commerical fishermen, product manufacturers, architects, builders, cities, townships, and bar and restaurant owners have all been bearing the brunt of ballooning rates or the loss of liability coverage altogether. Often these individuals or groups have excellent malpractice records, but now can't buy insurance at any price.

Recent activities in the insurance industry cannot be ignored if we are to seriously review how we have arrived at a nationwide problem of staggering jury awards and spiralling premiums. In 1983 two prevailing conditions merged with significant results. First, the insurance industry was dealing with its own economic changes -- as interest rates mounted, investments took off. By 1984, interest rates had fallen and investment returns were no longer able to do much more than offset operating expenses. The "capacity crunch" resulted from the shrinking profits of the primary insurers and withdrawals from the market by re-insurers. The response was to raise premiums and terminate the underwriting of certain risks.

Coupled with this, the legal system underwent several changes affecting the extent of sovereign immunity. States and localities became increasingly susceptible to lawsuits, as well as vulnerable in their ability to retain or obtain coverage.

The concerns regarding the setting of premiums will be addressed at our second hearing, however I would like to say that a greater amount of reliable and unbiased data is needed before legislative conclusions can be drawn. Currently, most of the statistical information about liability insurance is kept by the insurers, themselves.

One fact that no one disputes is that premiums are skyrocketing and health care is suffering. Some doctors are refusing to accept new patients or treat high-risk ones. Some are no longer delivering babies and many are ordering more procedures than good sense may dictate because they fear their judgement may be cross-examined in court. This type of defensive medicine is causing the patients, as well as the federal government, billions of dollars each year.

In Massachusetts, the malpractice crisis is not only driving doctors out of high-risk specialties, but midwives, dentists, community health centers, and family planning clinics are all feeling the crunch. The impact is a reduced availability of practitioners, restrictions in access of maternity care for pregnant women, and again, increased costs.

An issue that merits close attention and I hope will be addressed today, is the issue of physician discipline. A recent article in the Orlando Sentinel states that "despite claims to the contrary, the most-sued doctors are not those who take the toughest cases or are practicing on the leading edge of technology. Four of Florida's nine most-sued doctors have been investigated by state officials for violating minimum standards of medical care. Their mistakes included operating on a wrong knee, botching abortions, selling illegal drugs and performing routine surgery with fatal results."

In many respects, we are all responsible for the lack of protection given to the public against physicians who repeatedly practice poor medicine. This responsibility lies with state regulators, medical societies, and hospitals who have all shown themselves to be slow in accusing doctors of failing to follow, what in many cases, is just basic medicine. No reform package would be complete without addressing physician discipline and especially because these steps can be taken immediately.

While there is no formal consensus on the problems and proposed reforms, I am confident that today's panelists will help us to be better able to identify the needs and recognize our responsibilities on the federal level.

STATEMENT OF SENATOR CHARLES E. GRASSLEY AT A HEARING OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES ON THE SUBJECT OF MEDICAL MALPRACTICE INSURANCE ON WEDNESDAY, MAY 7, 1986.

THANK YOU, MR. CHAIRMAN.

THE GROWING COST OF MEDICAL MALPRACTICE INSURANCE, OR, IN SOME CASES, THE UNAVAILABILITY OF SUCH INSURANCE AT ANY PRICE, PRESENTS US WITH A PROBLEM OF MAJOR PROPORTIONS. ABOUT THAT, THERE DOES NOT SEEM TO BE MUCH DOUBT OR MUCH DISAGREEMENT.

IN RECENT MONTHS, THERE HAS BEEN AN IMPRESSIVE INCREASE IN PUBLIC AWARENESS OF THE DIMENSIONS OF THE GENERAL PRODUCT LIABILITY INSURANCE PROBLEM. THE REASON FOR THIS IS OBVIOUS. AND THAT IS THAT MANY MORE PEOPLE ARE BEGINNING TO EXPERIENCE THIS PROBLEM FIRST HAND. ORGANIZERS OF SPORTS EVENTS, CIVIC AND VOLUNTARY COMMUNITY ACTIVITIES, MUNICIPAL GOVERNMENTS, AND BUSINESSES AND INDUSTRIES OF EVERY KIND ARE HAVING PROBLEMS OF VARYING DEGREES OF SERIOUSNESS IN OBTAINING LIABILITY INSURANCE.

HOSPITALS, AND PHYSICIANS AND OTHER HEALTH PROFESSIONALS ARE ALSO FACING SERIOUS PROBLEMS IN OBTAINING LIABILITY INSURANCE, AS WE WILL HEAR TODAY FROM OUR WITNESSES. THIS GROWING MEDICAL MALPRACTICE INSURANCE PROBLEM SEEMS TO BE CREATING A MAJOR THREAT TO THE AVAILABILITY OF HEALTH CARE. WHEN WE BEGIN TO SEE PHYSICIANS RETIRING FROM PRACTICE EARLY, OR WITHDRAWING FROM CERTAIN KINDS OF HIGH-RISK SPECIALTIES ENTIRELY, WE KNOW WE ARE FACING A SERIOUS PROBLEM. AND ALTHOUGH WE

ARE PROBABLY NOT BEGINNING TO FACE OVERALL PHYSICIAN SHORTAGES AS A CONSEQUENCE OF THIS PROBLEM, WE DO SEEM TO BE FACING PROBLEMS OF UNAVAILABILITY OF CERTAIN KINDS OF MEDICAL SERVICE IN SOME PLACES AROUND THE COUNTRY BECAUSE OF THE DIFFICULTY PHYSICIANS AND HOSPITALS ARE HAVING IN GETTING AFFORDABLE LIABILITY INSURANCE.

THERE ALSO APPEARS TO BE A GROWING REALIZATION THAT THE SOURCES OF THIS PROBLEM ARE COMPLEX, AND THAT DEFINITIVE SOLUTIONS TO IT, THEREFORE, WILL NOT BE EASILY COME BY.

OUR HEARING TODAY SHOULD BE A USEFUL START AS WE TRY TO DETERMINE WHETHER THERE IS A FEDERAL CONTRIBUTION TO BE MADE TO THE SOLUTION TO THIS PROBLEM. CERTAINLY, IT WILL BE HELPFUL TO HEAR COMMENTARY AND ANALYSIS, AS WE WILL TODAY, ON THE TORT CLAIMS SYSTEM, AND ON THE BILL WHICH SENATORS HATCH AND INNOUYE HAVE INTRODUCED, AND ON THE SITUATION FACING THE PROPERTY-CASUALTY INSURANCE INDUSTRY.

MR. CHAIRMAN, I HAVE NOTHING MORE TO SAY AT THIS TIME. I LOOK FORWARD TO THE TESTIMONY OF OUR WITNESSES.

The CHAIRMAN. Let me turn to Senator Kennedy at this point.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. Thank you very much, Mr. Chairman.

I think you have outlined the problem that we are facing in this Nation on a matter of enormous importance in the area of access to health care. We are all very much aware that it is not only in the health care area, but it is in the other professions as well, that there have been very sizable increases in terms of insurance premiums and liability.

But our principal function in terms of this committee is in the health care area. I would like to just underline one additional point which I think is of importance, and we are going to hear more about it during the course of the hearing. That is the high concentration of payments from malpractice suits that are focused on a relatively few number of physicians, and what opportunity is there for the various medical professional organizations to take action to see that those individuals are not going to be practicing medicine on the American consumer. What are their particular problems in doing so? Do they face as well challenges in terms of slander and perhaps even antitrust action for various medical associations trying to exclude incompetent doctors from hospital privileges?

That is something that I am hopeful that we can focus on to some degree as well, because I think we ought to start out, if this is a problem again in the medical area, what are the organizations, what is the medical profession doing to police themselves. And that ought to be the first order of business. I think all of us are very much aware that professionals generally do not have a very good record in policing themselves, whether we are talking about politicians or lawyers, or even in the medical profession.

But I am hopeful that we will have some comments to enlighten us on this committee about what we ought to know about that issue, is it taking place or isn't it taking place, because I think the various professions certainly have a responsibility to help us before we are considering the legislative approaches which have been suggested and recommended to us in the Senate.

I have an additional statement, Mr. Chairman, and I would just ask that it be included.

The CHAIRMAN. Well, thank you.

Without objection, we will include it in the record.

[The prepared statement Senator Kennedy follows:]

from the office of

Senator Edward M. Kennedy

of Massachusetts

Statement of Senator Edward M. Kennedy
May 7, 1986

The crisis in medical malpractice reaches from the operating room in every direction. An estimated 300,000 Americans each year are the victims of negligence in the practice of medicine, yet only 1 out of every twenty five victims is compensated for the injury. The crisis in medical malpractice spreads to the courtroom: an estimated 42,000 claims of medical malpractice were lodged last year, and the number is likely to increase.

The crisis reaches from the courtroom to the boardrooms of America's insurance companies and even to Lloyd's of London: insurance rates for those who practice medicine have mushroomed in the last two years and now threaten to drive many of our best professionals from the practice of medicine. And this is the terrible irony of medical malpractice -- unlike other areas of insurance where those with the worst histories pay higher premiums than those with good records, our system of medical malpractice insurance requires our best doctors to pay the high price for the mistakes of our worst. Premiums for all physicians have risen 44.8% in the last two years. A study in Pennsylvania found that 1% of the physicians in that state were responsible for 25% of he payments made from that state's excess risk pool. Studies in Florida, California and Michigan show similar results.

We must bear in mind that physicians are not the only victims of sky-high insurance increases -- architects, municipalities, day-care centers, peace marches, small businesses and even lawyers have been hit with insurance rates so high that the biggest risk they now face is how high their rates will go next year. Last year, liability premiums were 9.1 billion, an increase of 60% over 1983.

We want, through these hearings, to find the causes of the sudden insurance spiral. How much is caused by the rules of tort law? How much is caused by the failure to expel incompetent and impaired physicians from practice? How much is caused by the insurance companies' need to recover their losses after the wave of price-cutting in the early 80's?

Mr. Chairman, I thank you for convening these hearings on the medical malpractice crisis. On behalf of the minority and pursuant to Senate Rule 26(4)(d) I request that at the next hearing on this subject, the witnesses on this list be called to give their testimony for the benefit of the Committee's deliberations. I look forward to working with the Committee toward a solution of this pressing national problem.

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The **Chairman**. Now, we have received many more requests to testify today than could be accommodated in this hearing—in fact, we have 18 witnesses. So it is going to be a very difficult hearing as it is.

We have included witnesses at the request of the minority wherever possible for today, but there have been some ripples, and we are going to straighten that out and accommodate our ranking minority member as well as others. We will continue to consider all such requests out of accommodation and in the spirit of commitment.

As a matter of fact, we have requests from the National Perinatal Association and the American College of Nurse Midwives to include their statements in the record, and without objection, we will do that in this record today.

As to our witnesses today, I just have to tell all of you, in the interest of all of our time, that we are going to limit you strictly to 5 minutes. So do not go over. The minute this red light goes on, I am cutting you off, because otherwise we will be here until tomorrow. The important thing is to make this record, get your statements in. We will put them in the record in full, all statements of all witnesses.

Now, we would like you to summarize your testimony and conclude it as soon as you can. We would like you not to take the 5 minutes if you can help it.

Our first panel this morning consists of patients who have been affected or may be affected by a withdrawal of medical services that has come as a result of the malpractice insurance crisis.

Our witnesses on this panel are Mr. and Mrs. Paul Arnoldy of Auburn, ME; Mrs. Sherry Thomas, accompanied by her aunt, Mrs. Rosalie Anderson, both of Montgomery, AL; and Mr. John Stevens of District Heights, MD, accompanied by Mrs. Julia Doherty, executive director of the Prince Georges Volunteer Health Clinic in Capitol Heights, MD.

Now, I understand that only Mrs. Doherty has a prepared statement and that the other witnesses prefer that I develop their testimony through questions and answers. So if you folks will take your seats, we will begin with you, Mrs. Arnoldy, and we will go from there.

I might add that Mrs. Thomas' baby's name is Mathew; Mrs. Arnoldy's baby's name is Joseph, and Mr. Stevens' son is John, Jr.

So we are happy to have those witnesses at the table as well.

STATEMENT OF MR. AND MRS. PAUL ARNOLDY, AUBURN, ME; SHERRY THOMAS AND ROSALIE ANDERSON, MONTGOMERY, AL, AND JOHN STEVENS, ACCOMPANIED BY JULIA DOHERTY, EXECUTIVE DIRECTOR, PRINCE GEORGES VOLUNTEER HEALTH CLINIC, CAPITOL HEIGHTS, MD

The **Chairman**. Now, Mrs. Arnoldy, in what way has the malpractice insurance crisis affected the quality and availability of your health care?

Mrs. **Arnoldy**. First of all, I would like to say that I am very grateful that I was able to testify today. Through my personal experience, I really have a feeling for this situation that we are in.

I also regret that my physician, my obstetrician that I previously had, Dr. Druin, was unable to attend today.

What has happened in my personal experience has been that I had been with Dr. Druin for 8 years, and he has been my obstetrician-gynecologist. We have had infertility for 8 years. When I went through the in vitro fertilization program, I was positive pregnancy tested in the summer of 1985, and I called Dr. Druin, who was my physician, and told him the good news, and he unfortunately told me that he had some bad news. Because of the malpractice insurance rates, in 1975, he had $2,300 for malpractice insurance, which went up to $24,000 in 1985, which he dropped out of being an obstetrician.

If he continued practicing in 1986, his insurance rate would have been $35,900.

In the Liston-Auburn area, we do have a low income; the average income is $15,000. So to our community, that was extremely damaging.

The CHAIRMAN. So it would have been tough.

Mrs. ARNOLDY. As far as my personal experience, I had to travel to Portland, ME, which is about 35 miles, during the winter in order to get a high-risk obstetrician. Now, the reason I needed that was that due to the in vitro fertilization program, there is a 25-percent miscarriage rate the first 3 months. So I needed a high-risk obstetrician. There were none other than Dr. Druin in the Liston-Auburn area.

The CHAIRMAN. How far did you have to drive each time you went to get care?

Mrs. ARNOLDY. It was 35 miles. The last 4 weeks of my pregnancy, I had to go twice a week, which meant that I needed to get a substitute—I am a schoolteacher—and so it affected my job. It also affected emotionally. Dr. Druin and I have worked together throughout the last 8 years and developed and unbelievable rapport, and I had utmost confidence in his ability. Starting out with a new physician made it very difficult for me.

The CHAIRMAN. Were you satisfied with the level of care you received in Portland from the substitute doctor—was it Dr. Benert?

Mrs. ARNOLDY. Dr. Harry Benert. Yes; I was very satisfied, although it was very difficult. Again, the traveling during the winter months, and going through the ice and the snowstorms; not being able to travel alone, and my husband had to get out of work, and that made it very difficult. He traveled from Waterville, ME. So we needed to get a four-wheel drive to get him from work to pick me up and take me to the physician.

The CHAIRMAN. Actually, it was about a 78-mile roundtrip drive.

Mrs. ARNOLDY. Yes; it was.

The CHAIRMAN. In the winter in Maine, that is pretty bad, isn't it?

Mrs. ARNOLDY. Very. It is very dangerous. Plus, because I was high-risk, we always ran the concern that maybe something would happen with me through the pregnancy, and we would not be able to get to the hospital in time.

The CHAIRMAN. Now, let me ask your husband this question, if you would just move the mike over to him. Mr. Arnoldy, as I understand it, your wife just mentioned that you had to take time off from your job to drive your wife over to Portland.

Could you tell us a little bit about your job and how that affected you?

Mr. ARNOLDY. I am a baker in Waterville, ME.

The CHAIRMAN. How far is Waterville, ME from Portland?

Mr. ARNOLDY. My house to Waterville is 64 miles. Add that from Waterville, when I had to leave for the doctor's appointment, to Portland, it is 102 miles. That is one-way, right from Waterville. So if the doctor had an appointment for 10 or 11 o'clock in the morning, I could not go to work; it took too much time.

The CHAIRMAN. How many times did you have to take off work during this period?

Mr. ARNOLDY. The last 2 months, 2 days out of every week.

The CHAIRMAN. So it was a number of times, then.

Mr. ARNOLDY. Numerous times. I have done the roundtrip at least six times from Waterville, down to Portland, and back to Waterville, because my job deals with perishable goods, and I just have to be there; I am one of the managers there.

The CHAIRMAN. Your wife indicated that you had to buy a four-wheel drive, as I understand, which was a Bronco, to make the trip?

Mr. ARNOLDY. Yes. We had a small compact station wagon. I did not feel that was adequate enough to get us to Portland if something would happen. We do have some severe storms, and I did not want to take the chance.

The CHAIRMAN. Well, if the malpractice crisis had not forced Dr. Druin out of his obstetrical practice, I guess your wife, Kathy, could have made the drive herself. It was only, what, 2 miles roundtrip to his office and back home?

Mr. ARNOLDY. Yes, definitely.

The CHAIRMAN. So you would not have had to take off work?

Mr. ARNOLDY. No. I would have felt very comfortable with that.

The CHAIRMAN. Were there any other inconveniences, Mrs. Arnoldy, that you can let us know about here today?

Mrs. ARNOLDY. Putting it in a nutshell, I believe the emotional part was the most draining for me. Again, having a relationship with Dr. Druin, feeling very comfortable in his medical judgments, having him know my physical body as well as my emotional condition. The high risk of the in vitro made it very strenuous on all of us. Even though we were very fortunate in not having any problems along the way, it was very difficult. If I can state it enough, it was really a dreadful experience having Dr. Druin give up his practice. It made it very difficult on all of us.

The CHAIRMAN. Well, as you know, Mrs. Arnoldy, the committee is considering legislation to help solve the malpractice insurance crisis through a number of different steps that could possibly mean compromises by everybody involved, including persons who file lawsuits for malpractice

Do you think any limitations on jury awards for noneconomic damages—that is, pain and suffering—do you think those are too high a price to pay for getting the Dr. Druins of this country back into the practice of obstetrics and other specialties that they are leaving as a result of the medical malpractice crisis?

Mrs. **Arnoldy**. I would like to see a more commonsense approach. And I understand the reasons for malpractice insurance. But again, the frivolous suits, I believe, are costing us too much as far as services. And in the State of Maine, it is a rural area, and our obstetricians are taking the choice that they choose not to provide lesser care to their clientele, and I see that as very damaging.

The **Chairman**. Thank you.

Let me turn to Senator Kennedy and then we will move on to Mrs. Thomas and Mrs. Anderson.

Senator **Kennedy**. Thank you, Mr. Chairman.

Do you go to the Medical Center in Portland?

Mrs. **Arnoldy**. The hospital?

Senator **Kennedy**. Yes, the hospital.

Mrs. **Arnoldy**. Yes; Portland Maine Med.

Senator **Kennedy**. Well, you are certainly fortunate. I think that center is probably one of the best we have in the country in terms of infant mortality and care. It has an extraordinary record.

I suppose there are many others similar to yourself who have perhaps not had the in vitropregnancy but who were involved in childbearing, and that doctor was not available to any of them, either, was he?

Mrs. **Arnoldy**. No, he was not, especially if they were higher risk.

Senator **Kennedy**. So your story is really replicated by scores of other families in that community.

Mrs. **Arnoldy**. I believe so.

Senator **Kennedy**. And I think as we will see in the course of the morning, it is replicated by scores of families all over the country.

Let me just ask you, did you have any awareness whether the doctor had any claims against him for any kind of malpractice?

Mrs. **Arnoldy**. Dr. Druin.

Senator **Kennedy**. Yes.

Mrs. **Arnoldy**. Yes, I believe had one suit about 8 years ago. And as far as I know, that was the only one. And it was not a life-threatening situation.

Senator **Kennedy**. This is another part of the problem which I think we will find over the course of the hearing, that your doctor is paying a very high premium, and the premium is not related to his kind of service and his kind of professional capability. We find out he is paying probably the same rate as somebody else in Maine, or perhaps even across the country, and it is completely unrelated to perhaps a lifetime of good service to the people in that community. And that is certainly not right, and it is probably related to the fact that maybe other doctors are not providing as good service, and they get claims against them, and those people continue to practice, and your doctor's rates just keep going up, and he just cannot deal with it. So it is a complicated question, but I think you make a very, very helpful commentary to this committee about how the effects of this increase in premium have really affected the Arnoldy family and many others.

Mrs. **Arnoldy**. If I may add, in my discussions with Dr. Druin, he said he felt he had two options. One, he could raise his service price, what he would charge for people in our community—and again, it is a lower income community—or he could take on more clients, and we would all receive lesser care. And he chose not to do that.

Mr. **Arnoldy**. There is one more thing, also. Going back, you asked did Dr. Druin have a lot of other patients like this. He did. And going to Dr. Benert in Portland, he was a very adequate doctor, but I never felt comfortable with going to Portland, because Dr. Druin had operated on my wife twice previously. And in Dr. Benert's office, we had to wait an hour and 45 minutes every time that we went down there. The man was very, very busy. He is a very adequate doctor, but he is very busy. And he tries hard. But there are more people like us going to him because there is no one else delivering babies because of the possibility of suits.

It is catching up to a lot of doctors—and people, also.

Senator **Kennedy**. Thank you.

The **Chairman**. Thank you, Senator Kennedy.

I might mention that the one case that Dr. Druin had was settled for a nominal amount, according to his insurance adjuster. He said it was a frivolous case, settled for a very frivolous amount.

Senator Pell, we will turn to you.

Senator **Pell**. Thank you very much, Mr. Chairman, and I congratulate you on holding this hearing. I am very glad indeed to be a cosponsor with you of S. 1804.

The **Chairman**. Thank you.

Senator **Pell**. This problem of medical malpractice is, as we all know, a very sharp and acute one. But the problem is even more wide than that of just medical malpractice alone. It is a generic problem, where liability insurance could mean a whole variety of problems which are upon us.

And my only thought is that as we work on legislation, we ought to think of it in as broad terms as possible, so we will include not just the specifics of medical malpractice.

I have a statement I would like to have inserted in the record as if read.

The **Chairman**. Without objection, we will place that in the record before our witnesses.

Senator Metzenbaum.

Senator **Metzenbaum**. Just very briefly, the issue of malpractice insurance as well as the whole issue of insurance generally in this country at the moment is a very challenging one, because it is very difficult to find the facts.

Business Week just had a very interesting story on the subject, and it is not a one-sided issue. I think people who are particularly suffering are consumers such as these, who have difficulty in finding doctors; small businesspeople have difficulty in obtaining insurance. And I think that this is an instance in which the people in the industry ought to be solving the problem, but I am certain that they are not, and therefore, I believe the Government will have to step in, but it is an area in which Government should not have to step in, but we have no alternative.

The **Chairman**. I agree. Thank you, Senator Metzenbaum. And we will place any statement you have in the record at the appropriate place, as well.

Senator **Metzenbaum**. I thank you very much. I will have one.

The **Chairman**. Let me turn to you, Mrs. Thomas.

I understand you have strong feelings that the health of you and your family has been jeopardized because of the withdrawal of services that you think resulted from this medical malpractice and insurance crisis that we have been talking about; is that correct?

Mrs. THOMAS. Yes, that is right.

The CHAIRMAN. All right. Now, will you summarize for the committee the incident involved, as to how you think it is related to the malpractice insurance crisis?

Mrs. THOMAS. OK. First of all, after having labor pains starting around 3 o'clock, I awakened my husband about 6, and I told him I was having contractions.

At that time, he called a neighbor, and she came down and timed my contractions from 3 to 4 minutes.

At that time, I got dressed, and we left and went to the nearest hospital. When we arrived at Baptist, the emergency that night, the nurses downstairs asked me if I had a private physician.

At that time, I told them that I had been seeing a private physician, but up until my seventh month. After that, I could not afford to keep going to him, and I started going to the clinic.

They took me on upstairs, and as I got up there, the nurses asked again if I had a private doctor, and I told them no, I had been going to the clinic, so he had been seeing me for the last 2 months.

Well, then the nurse told her just put me in any room; it did not matter. After I told them I was going to the clinic, it seemed as if their attitude toward me had changed.

At that time, they hooked me up, and about an hour later, the doctor came in, and he checked me. And he told me that my contractions were only 2 to 3 minutes apart. He told me that I had not dilated but 2 centimeters, and that I needed to go home, take a Tylenol and put my legs up, because I was having false labor pains.

At that time, I told him I was in labor because I was hurting so bad. But he told me there was nothing he could do; to go home.

At that time, the nurse came in, and helped me get dressed—well, my husband helped me get dressed; she did not.

I got out to the hall, and I told her I was hurting so bad that I could not walk. And she told me, "Any lady in labor can walk."

"Well," I said, "I can't."

So at that time, my aunt told her, "Well, just get me a wheelchair, and I will take her down myself."

And she said, "Well, I will get her, but you are just going to have to hurry up, because I have got to set up for a C-section."

Well, she did not help me in the chair; my aunt did. She rushed me down, and she told my husband, "Hurry up and get the car," because she had to hurry upstairs, and she did not have time to wait on us.

At that time, she took me downstairs, and she just left me standing there. I was hurting real bad then, and I told them that I was not going to make it home. Well, they did not accept me back.

So I had to go home. I was home about 30 minutes, and I started having contractions real bad again. We called back to the hospital, and my husband told them that I would be seeing Dr. Williams the following week. Dr. Williams is a physician at Baptist; he is a private physician. Well, he was out of town, so we called his assistant. His assistant told us to come on in.

By the time I got dressed again, got to the door, his assistant called and said he could not accept me, that I would have to go to the next emergency, which was Jackson. And from my house to Jackson, it is about 11 miles.

I did not make it. I did not make it to Jackson. I gave birth to my baby in the car. By the time I reached Jackson, Dr. Felice was oncall. And he asked me why didn't I go to the emergency that morning. I explained to him that I had gone, that they had turned me around because they said I was in false labor pain. And he said that the doctor there should have known that the baby would have come at any time with this being my second child.

He did not know at the time that this was my second child. I explained to them at Baptist that this was. But——

The CHAIRMAN. Let me see if I can help you. As I understand it, the doctors, the obstetricians in Montgomery, AL, had threatened to cease delivering babies in that area in Montgomery—and certainly, in emergency rooms of the local hospitals—because of the risks of being sued.

Mrs. THOMAS. OK. At the time that this was happening, I was not really thinking about the malpractice and all, you know——

The CHAIRMAN. Yes, I can imagine. [Laughter.]

I have not even been thinking about it as you have been telling the story. [Laughter.]

Mrs. THOMAS. But after arriving at Jackson, I got to thinking, after reading the press release, and it stated that a lot of doctors were turning patients away because of the malpractice liability risk, you know, I started wondering, was that the reason that they turned me around.

And I feel strongly that it was, but that was not my case, because I had had prenatal care up until my 7th month—well, I had it all the way through, but I do not feel that they thought I did, and they did not want to risk accepting me. I was not a high-risk patient.

The CHAIRMAN. Let me just say this. The doctors in Montgomery issued a press release, I think it was January 22 of this year——

Mrs. THOMAS. That is right.

The CHAIRMAN. And in that release—I will just put it in the record so everybody can see it—but they list obstetrics as No. 1 "malpractice liability risk." In fact, they say, "Continued delivery of unattached obstetric patients beyond May 1, however, is in jeopardy for the following reasons: (1) malpractice liability risk * * *," and then they list the reasons.

They say, "Obstetricians are currently being sued more often than any other medical specialty. Obstetricians make up about 7 percent of all physicians nationwide, and yet 12 to 14 percent of all medical claims are against obstetricians.

"Furthermore, 73 percent of all obstetricians have been sued at least once."

And then, "(2) extraordinary increase in the number of unattached obstetric patients over the last 10 years." They listed that as a reason.

I will just put it all in, but let me just read the headline of No. 4: "Unattached obstetric patients regrettably have a higher potential for being complicated births."

So I can see what you had to face at that particular time when the hospital really refused to help you.

[Information supplied follows:]

PRESS RELEASE FROM MONTGOMERY OBSTETRICIANS

RELEASE DATE: JANUARY 22, 1936

Montgomery obstetricians today announced they would continue to deliver unattached obstetrics patients for an additional 90 days beyond February 1. They were represented by Dr. Joseph Ferlisi, spokesman for the group.

Montgomery obstetricians have, over the past six weeks, met with representatives from federal, state, and local health agencies, from local health clinics, from the State Medical Association, and city, county and state government officials, in an effort to find a solution to the unattached obstetrics patient problem in Montgomery County.

"We feel that positive steps have been made toward this end as a result of these meetings," said Dr. Joseph Ferlisi. "It is on the basis of these efforts," he further stated, "that most Montgomery obstetricians will continue to provide this needed care for an additional 90 days beyond February 1. This, of course, is provided these efforts continue in a forward manner."

The following efforts have been made to try to alleviate this problem:

a. Public health representatives have stated they are actively recruiting public health obstetricians for this area;

b. The public health obstetrician at Lister Hill Clinic has agreed to participate in the Emergency Room rotation;

c. Legislation has been introduced to address the malpractice liability risk situation;

d. The State Medical Association has met with the obstetricians, recognizes the problem, and has agreed to assist in a solution.

"Montgomery obstetricians have always recognized, and continue to recognize, the plight of the unattached obstetric patient (patients who, for whatever reason, have not been under the care of the delivering obstetrician during the term of their pregnancy)," said Dr. Ferlisi. "Obstetricians have willingly cared for these patients over the years," he said, "just as most physicians from all other medical specialties have cared for unattached patients with other medical needs."

Continued delivery of unattached obstetrics patients beyond May 1, however, is in jeopardy for the following reasons:

1' [illegible]

1. Malpractice liability risk. Obstetricians are currently being sued more often than any other medical specialty. Obstetricians make up about 7% of all physicians nationwide, yet 12% to 14% of all medical claims are against obstetricians. Furthermore, 73% of all obstetricians have been sued at least once.

2. Extraordinary increase in number of unattached obstetrics patients over the last ten years. In 1975, obstetricians at Baptist, Jackson and St. Margaret's hospitals cared for approximately 200 unattached obstetrics patients. In 1985 this load increased to more than 900 unattached obstetrics patients.

3. Decrease in number of obstetricians in Montgomery County. Malpractice liability risk is the number one reason why obstetricians are quitting this field. Since May 1985, six Montgomery OB-GYN physicians have stopped practicing obstetrics. A loss of two more obstetricians is anticipated by June 1986. This is true for family practitioners as well. Family practitioners who have been delivering babies in Montgomery and surrounding counties are finding it increasingly difficult, if not impossible, to obtain malpractice liability insurance for obstetrics.

4. Unattached obstetrics patients, regrettably, have a higher potential for being complicated births. These mothers have received little or no prenatal care at all. Even if prenatal care has been made available, the delivering obstetricians see these patients for the very first time at the time of delivery. There is little time for them to familiarize themselves with the particulars of each individual case. It is too late to perform needed testing that might alert obstetricians to potential complications. This lack of continuity of care increases the risk to unattached mothers and, consequently, to the obstetricians.

5. Distribution of unattached obstetrics patients to Montgomery obstetricians is inequitable. The Montgomery Emergency Room rotation system calls for each of Montgomery's three major hospitals to assume one third of the total indigent care load. Because of the hospital affiliation of the various obstetricians, however, some obstetricians may have to deliver as many as 13 or more unattached obstetrics patients per month, in addition to their regular patient

load. Some of the obstetricians have expressed a willingness to broaden their primary hospital affiliation and deliver at other hospitals in order to equalize this distribution of physicians at the various hospitals for this type of care. Because many of the obstetricians are in solo practice, however, there has been some reluctance in the past to take call at other hospitals because one individual cannot be at two places at the same time.

6. Other factors. Montgomery obstetricians feel that little, if any, incentive is present in the current system to distinguish the "truly needy" unattached patient from those patients who simply take the current system for granted. They further feel that not enough is being done to educate today's young men and women on family planning.

"Complete resolution of this problem will not be easy and cannot be done overnight," said Dr. Ferlisi. He further added that in order for most Montgomery obstetricians to be able to continue to provide the needed care to the unattached patients beyond May 1, however, concrete and positive efforts need to continue to be made in the following directions:

1. Relief from the malpractice liability risk factor. This might include pursuit of the extension of the Good Samaritan Act for those physicians providing services to unattached patients who present themselves at the City Emergency Rooms. Another form of relief might be consideration of liability coverage by city and/or county governments for medical care provided as a community service.

2. Serious consideration of the establishment of one central location where quality care can be provided for the unattached obstetrics patient. This would include prenatal care, delivery, and family planning.

3. Provision for fiscal responsibility from adjoining counties whose patients present themselves in Montgomery City Emergency Rooms. Laws already on the books fail to provide a mechanism for these surrounding counties which would enable them to comply with this legislation.

"Montgomery area obstetricians have worked diligently over the past several months to try to find a solution to this very serious problem - and will continue to do so. But the problem is a social one, and one that can only be successfully solved with the participation and cooperation of all parties involved, including obstetricians, health agencies, local governments, patients, and the community at large," said Dr. Ferlisi.

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The CHAIRMAN. Now, although this announcement extended emergency room deliveries for another 90 days, I think it is illustrative of how the doctors were thinking at the time and what they were thinking.

The press release said, "Continued delivery of unattached obstetric patients, meaning emergency room deliveries of persons who have not been attended by a delivering physician, is in jeopardy for the following reasons."

The first reason it lists is the malpractice liability problem and then it lists some of the other reasons as well.

Now, I think after reading that, do you feel that the reason that they turned you away, really, was because of their insurance risk and the malpractice problems that they had?

Mrs. THOMAS. Insurance risk, yes.

The CHAIRMAN. You felt that that was what it was. Did they tell you that?

Mrs. THOMAS. No, they did not have to. It was something that I just felt. And after talking to a couple of nurses there and talking to the doctors, and telling them that—well, when I arrived at the hospital downstairs, when I told them that I had been seeing Dr. Williams, everything was going real smooth, but after going upstairs and telling them that I had been going to a clinic, the attitude toward me changed completely. And that is when I just felt that it was something to do with the clinic, the high risk of all of the young girls not having that prenatal care which I had had, and which I had explained to them that I had had.

The CHAIRMAN. All right. Let me just put your brief statement in the record. I think it makes a pretty good case that you were really just shunted aside because you were considered an emergency room patient and a high-risk patient, even though this was your second child, and you did not feel you were high risk at all.

I would just put that in the record at this point.

Mrs. THOMAS. When I explained to them that I was to see Dr. Williams the following week, when we called back to the hospital, I explained that to them, but they still did not accept me. They told me I would have to go to whatever emergency that was at the time, and that was Jackson.

So it was like they did not care if I made it there or not, or if I was seeing Dr. Williams or not. I had not been seeing them, so you know, ~~it~~ was not up to them to deliver the baby; emergency was to do it.

[The prepared statement of Mr. and Mrs. Thomas follows:]

STATEMENT OF SHERRY AND LARRY THOMAS

To the Committee, Sen. Hatch and Mr. Phillips, I am honored that I have been asked to Come to express my feelings and grievances as to my treatment during my time of labor and Child birth.

This May not be of help to me, but Maybe it will help some one else who will Come along, who may not have money or insurance to Cover the medical bills.

I see the problem as I see a busy intersection, every one Can know that there is a need for a traffic light, and yet will wait until there is a lost of life before anything is done.

I feel, but by the grace of God, this Could very well have been my life or my baby's. We live in a Country where there is great wealth, yet there are those who do not have what is Necessary to maintain good health, and life.

I am a tax payer, I work 6 days a week, my husband worked part time, my job has insurance - explain what happen with your insurance. yet the bills were paid, but there are [illegible] others who have nothing but Clinic help, and everyone is entitle to receive necessary medical help and food, if not, then the medical oath is a lie and they should take it down from their facilities.

Thank you all
Sherry + Larry Thomas

The CHAIRMAN. Let me switch that microphone over to Mrs. Anderson and just ask you a few questions, Mrs. Anderson, if you could bring the mike up close.

I understand you were present when Mrs. Thomas was turned away from the hospital; is that correct?

Mrs. ANDERSON. Yes, I was.

The CHAIRMAN. And did you observe the contractions that were occurring about 2 to 3 minutes apart at that time?

Mrs. ANDERSON. Yes, they were.

The CHAIRMAN. You personally saw that?

Mrs. ANDERSON. Yes, I saw that.

The CHAIRMAN. Were there any other witnesses present?

Mrs. ANDERSON. Yes, a couple more, one of which was her husband, and one of her neighbors was with her. You see, really, what happened, when she called me, I was at home, and she phoned me and told me that she was in labor—I cannot talk—it hurts——

The CHAIRMAN. That is all right. You just relax.

Was your neighbor Julene Mathews?

Mrs. ANDERSON. Right.

The CHAIRMAN. Do you have a statement from Mrs. Mathews? Why don't we put that in the record at this point, too, and that will save you some time.

[The prepared statement of Mrs. Mathews follows:]

STATEMENT OF JURLEAN MATHEWS

3731 Woodley Road #9-F
Montgomery, Alabama
May 5, 1986

To whom it may concern:

On January 18, 1986, I received a telephone call from Mrs. Sherry Thomas sister (Shirley Price) to please come down stairs and help out with her sister who was in pain. This was around 4:00 am.

I went down stairs to Mrs. Thomas apartment to see if I could be of any help to her, while there I timed Mrs. Thomas's laber pains, her pains were 5 minutes apart, about an hour later some of her pains were 3 minutes apart at that time we were convinced it was time for her to go to the emergency room.

We drove to Baptist hospital which were the emergency hospital for that day; this was around 6:00 am. Upon arriving at Baptist hospital Mrs. Thomas husband (Larry Thomas) and I stopped at the emergency room front desk to answer questions and fill out necessary papers. Mrs. Thomas begin to complain more and more of labor pains until the attending nurse dicided to take her on upstairs, which I followed.

We stayed at Baptist hospital approximately 2 hours. I was not allowed to go in examing room with Mrs. Thomas but when she came out I asked her, why didn't the doctor keep her: she stated: "The doctor said I am no where near having my baby yet it will be another month or so before I have my baby". Mrs. Thomas then stated: "I hope it is not because I told them I do not have a doctor, and I have been attending the Health Clinic,

We returned home at 8:00 am, only 5 minutes drive from Baptist hospital.

I received a call about an hour later from Mrs. Thomas sister stating that Mrs. Thomas had had her baby in the car in route to Jackson's hospital which was the next emergency hospital for that day as of 7:00 that morning. Mrs. Price (sister) did not know exactly how they were doing at the time, being she had also returned home.

I left the house again in route to Jackson's hospital, while on my way I stopped by Baptist to let them know that the young lady they had just sent home with the knowledge of not having her baby for another month or so, had just had her baby in husband's car in route to Jackson's hospital and that I hoped Mrs. Thomas and baby would be doing fine once I reached there for the sake of the doctor and attending staff on duty that particular morning.

When I reached Jackson's I noticed that the doctor on duty kept Mrs. Thomas in delivery room to make sure she did not have any complocations, also kept the baby in heated glass container to make sure he did not pick up any bacteria from his unique delivery.

If you need any further information please do not hesitate to contact me at this number (205) 284-4633.

Sincerely,
Jurlean Mathews
Jurlean Mathews

The CHAIRMAN. I think basically we have the general idea, and with your statement, Mrs. Thomas, in the record and Mrs. Matthews' statement, I think that will help us a lot.

Mrs. ANDERSON. Well, let me say this. I have got to get it out. It has been in me ever since this happened.

The CHAIRMAN. All right.

Mrs. ANDERSON. Just give me a little time, because I get all upset.

The CHAIRMAN. Sure. You just take your time.

Mrs. ANDERSON. This has not been the first time that it happened at Baptist Hospital. This is, to my knowing, the third time that the same thing happened. And I think something needs to be done about it, because people who are able, they do not get good treatment there, and then people who are able do not get good treatment.

The CHAIRMAN. OK.

Mrs. ANDERSON. You take this girl that I raised from sixth grade on up to now, and she is 33 years old. She went there. Then a friend went there And she had her baby in the parking lot. They turned her down. A little girl that I raised, she went there to have her baby, and her husband was supposed to have been in the delivery room with her, and they never did call him in. She had to get up off the bed and call her husband in herself.

And they just really did not treat her right, and I know they have money.

The CHAIRMAN. Well, let us just hope we can do something about this. We are really looking at it, and your testimony is very important to us here today.

Mrs. ANDERSON. It is not the color of the skin, black and white are being treated like this, and I think something needs to be done.

The CHAIRMAN. We appreciate you being here, Mrs. Anderson.

Senator Kennedy, do you have any questions?

Senator KENNEDY. I want to thank all of the panelists for sharing what I know are difficult experiences with us. But through that process, hopefully, we will be able to deal with some of these questions so that they will not happen in the future.

Mrs. Thomas, you were seeing a doctor in the early part of your pregnancy, were you not?

Mrs. THOMAS. Yes, I was seeing a doctor.

Senator KENNEDY. And then at some time, you went from the doctor to the clinic; is that right?

Mrs. THOMAS. Right.

Senator KENNEDY. And why was that? Did that have to do with your financial situation?

Mrs. THOMAS. Yes.

Senator KENNEDY. It did.

Mrs. THOMAS. Up until my seventh month, I had been working, but after my seventh month I went on maternity, and at that time, the accountant at Dr. Williams, office advised me that the bill would be so high if my insurance did not cover it. We were not sure that my insurance was going to cover it, because it was a new job.

Senator KENNEDY. What kind of insurance did you have?

Mrs. **Thomas**. I have—it is with a bakery. I work for Flowers Bakery.

Senator **Kennedy**. All right.

Mrs. **Thomas**. And at that time she advised me maybe to go to a clinic or one of the other health places to get help. And that is why I went to the clinic, because I knew that I could not afford to keep seeing Dr. Williams.

Senator **Kennedy**. And at the time that you went to Baptist when you were expecting, did they mention any payments before you could get in the hospital? Did they ask you?

Mrs. **Thomas**. No. Well, they took me on upstairs, and my husband stayed downstairs. He had to sign some papers. But as far as having to pay anything, he did not at that time. I had paid Dr. Williams up until the seventh month. I only owed him 3 more payments.

Senator **Kennedy**. But when you went in, and you were going to have the baby, it was not the lack of your financial situation that excluded you?

Mrs. **Thomas**. No.

Senator **Kennedy**. Do you know, Mrs. Anderson, on these other two cases that you know about, whether these people did not have any insurance, or——

Mrs. **Anderson**. Yes, they had insurance.

Senator **Kennedy**. They had insurance, too?

Mrs. **Anderson**. Yes, they had insurance. And Dr. Williams was one of them—she was one of Dr. Williams' patients. And he is a very, very good doctor.

But that was after she entered into the hospital, this is when it happened, and Dr. Williams had not even gotten there.

Senator **Kennedy**. But the other two that were also excluded from the hospital——

Mrs. **Anderson**. Well, I could not—I know it happened. She said they just told her she was in false labor, and when she got back to her car, that was when she had the baby, in the parking lot. I cannot say too much about her, but I know that is what happened. I just wanted to put it out in the open that this has happened twice.

Senator **Kennedy**. Thank you very, very much.

The **Chairman**. Thank you.

Senator Pell.

Senator **Pell**. No questions, Mr. Chairman. Thank you.

The **Chairman**. Senator Metzenbaum.

Senator **Metzenbaum**. No questions.

The **Chairman**. Well, I want to thank you. I think that Matthew certainly turned out all right, and so has Joseph. You have beautiful babies, all of you people.

Mrs. **Thomas**. Excuse me. Could I just read a written statement that I have.

The **Chairman**. Let us put it in the record, Mrs. Thomas, in the interest of time. It really is an important statement, and I have it right here, and we will put it right in the record; OK?

Mrs. **Thomas**. All right.

Senator **Kennedy**. Could I ask Mrs. Thomas, the Baptist Hospital, is that primarily a black hospital, or primarily white?

Mrs. THOMAS. No, it is not.

Senator KENNEDY. Primarily white?

Mrs. THOMAS. Yes, it is.

Senator KENNEDY. And let me just finish on this.

The CHAIRMAN. OK.

Senator KENNEDY. Did you have any sense at all that you were being excluded because of your race?

Mrs. THOMAS. I did not feel that that was the reason, because of my race; I did not.

Senator KENNEDY. Fine. Thank you.

The CHAIRMAN. All right, thank you. You actually felt it was because of this malpractice problem?

Mrs. THOMAS. That is right, yes.

The CHAIRMAN. All right. Mrs. Doherty, you have a statement, so we will take your statement at this time.

Mrs. DOHERTY. Thank you. I appreciate having the chance to talk here, and in particular to be able to bring Mr. Stevens here to talk about the impact the insurance crisis has had on him and also on our clinic.

The Prince George's Volunter Health Clinic, to tell you a little bit about it——

The CHAIRMAN. May I welcome, Mr. Stevens. Your son, John, is with you. We are happy to have both of you here.

Senator KENNEDY. John, are you missing school today?

Mr. STEVENS, JR. Yes. [Laughter.]

The CHAIRMAN. John looks pretty happy here, I will tell you. He has an awfully nice smile on his face.

Mrs. Doherty.

Mrs. DOHERTY. As I say, the P.G. Volunteer Health Clinic is a private nonprofit agency funded by the United Way. Essentially, it was founded in 1970 to provide medical care and health education services to the working poor of the metropolitan area.

We are very small—our annual budget is only about $100,000, and our staff consists primarily of volunteers, which is particularly important in light of our problems in getting health insurance.

The clinic is not only funded by United Way, but also in part by the county health department and by the fees that we do collect from the patients; we do charge them on a sliding scale.

Last year we were able to serve more than 2,000 clients, most of whom were either unemployed or working poor. They were unable to afford health insurance or else, if they had insurance, unable to afford the deductibles and the charges that they would have had in a private doctor's office.

On a sliding scale, what we provide those people is: well-child care, sick care for adults and children, routine physical exams, and reproductive health care.

Mr. Stevens had brought his son, Johnny, in for treatment of psoriasis, which he will tell you about in a few minutes.

An important thing to note is that unlike some of these other people you are hearing from, the services that Johnny Stevens is receiving and that all of our clients receive are generally not high-risk services. We do not even provide prenatal care, and we do not provide any kind of surgery or other services that are labeled as high risk. And in fact, in 16 years of uninterrupted service, we have never been sued.

Despite this, we found ourselves suddenly deemed an apparent risk by the insurance industry, and this past February our carrier, Integrity Insurance Co., actually told us that they were going to cancel our policy within 30 days, our general liability policy.

They said that they had no problems with our clinic in particular—which they should not have, since we had not been sued—but that they were just deciding that they were no longer going to insure that particular class of business.

You might have read about it in the paper. There were four other clinics in the area that went through similar experiences at the same time. Fortunately, they were rescued by the D.C. Government's Volunteer Insurance Program. Since we were in Prince Georges County, we could not be rescued by that same program.

Naturally, we were a little upset about this, and if we remained open without malpractice coverage, we could not begin to pay the cost of legal defense in the event that someone did decide to sue us. But without the insurance, it was entirely possible to imagine a situation where our volunteers might jeopardize their own livelihood. And, after the amount of time that they commit every week—there are 25 of them committing 4 and 5 hours a week—it seemed an awful lot to be asking them to take on the risk of their personal assets.

We could not afford huge sums of money for the insurance, either, assuming we could get it in the first place.

Agent after agent told us that there was no insurance out there, regardless of the low risk that we represented, and that there was a moratorium on new policies for community health clinics.

We finally received one quote from a questionable company in the West Indies. They wanted $39,000 upfront, and that was before they accepted the application.

The CHAIRMAN. And your whole business is run on $100,000.

Mrs. DOHERTY. Yes. And that was a breakthrough, to get that quote. Obviously, that would have been a real burden and not really feasible for us.

We also, as you can see from my testimony, received a quote of a $24,000 minimum from another company, but they never followed through on that and said they could actually offer us a policy.

Surprisingly enough, our crisis came to a real abrupt end, though possibly a temporary end, when our carrier, Integrity, suddenly offered to renew our policy at $2,100, which was $700 less than the previous year.

It is tempting to conclude now for the clinic that everything is fine, that our worries are over, but they are not. The policy is only effective through next February, and at that time, we hope that integrity will renew again.

What our recent experience tells us, though, is that we really have no control over the process at all. We might get insurance; we might not.

The CHAIRMAN. As I understand, this policy is only good until next February, anyway.

Mrs. DOHERTY. That is right, yes.

The CHAIRMAN. Let me just ask you a couple of questions.

Senator **Metzenbaum**. Did they explain why, why they reversed signals?

Mrs. **Doherty**. No, they did not. We got the insurance through an agent, and the agent simply called us up; they could not really explain it. And they encouraged us not to ask questions, since the policy was exactly the same.

The **Chairman**. That you should be happy with the policy, yes.

Mrs. **Doherty**. And we paid the premium.

[The prepared statement of Mrs. Doherty and responses to question submitted by Senator Grassley follow:]

Testimony of

JULIA DOHERTY

Before the

COMMITTEE ON LABOR AND HUMAN RESOURCES

May 7, 1986

Good Morning. My name is Julia Doherty, and I am the Executive Director of the Prince George's Volunteer Health Clinic in Capitol Heights, Maryland. I appreciate this opportunity to describe to the Committee the effects of the insurance crisis on on our clinic and the people we serve.

The Prince George's Volunteer Health Clinic is a private, non-profit agency founded in 1970 to provide medical care and health education services to the working poor of the Washington Metropolitan area. We are very small--our annual budget is only about $100,000 and our staff consists primarily of volunteers. The Clinic is funded by the United Way, the Prince George's County Health Department, fees charged to clients, and other grants.

Last year we served more than 2,000 clients, most of whom are either unemployed or working poor who cannot afford regular health care or health insurance. We provide these people, on a sliding fee scale, such services as routine physical examinations, well-child care, minor medical care, gynecological care and reproductive health care. The Clinic performs no surgery, provides no prenatal care, or any other care that has been labeled as high-risk. It is worth noting that after more than 16 years of uninterrupted operation, the Clinic has never been sued.

Despite this, we found ourselves suddenly deemed an apparent bad risk by the insurance industry. Last February, our carrier--Integrity Insurance Co. of Paraumus, NJ--notified us it planned to cancel our policy in 30 days. Integrity said it had no problems with our clinic in particular, but that it simply didn't want to keep insuring our "class of business." And we weren't the only victims. Four other clinics in Washington received similar notification at the same time.

Naturally, we were stunned. If we remained open without malpractice coverage, we couldn't have begun to pay the cost of a legal defense in the event that someone did decide to sue us. Without insurance it was entirely possible to imagine a situation in which our volunteers might jeopardize their own livelihoods simply because they were helping those less fortunate than themselves. On the other hand, we couldn't afford huge sums for insurance, assuming we could get any in the first place.

Agent after agent told us there was no insurance out there, regardless of the low risk we represented. They told us there was a moratorium on new policies for community health clinics. We finally received one quote-- from a company based in the West Indies--but they wanted a check for $39,000 to even begin processing our application. That would have been more than 10 times our 1985 premium and more than one-third our annual budget. Several months later, Admiral Insurance Company said they would consider insuring the Clinic, but the cost would be at minimum $24,000. To date, Admiral has not agreed to insure the Clinic or given us a definite price.

Surprisingly enough, our crisis came to an abrupt (though possibly quite temporary) end when Integrity suddenly offered to renew our policy for only $2,100 a year. Amazingly, and for reasons I still don't understand myself, that price was actually $700 less than our rate in 1985.

It is tempting to conclude now that everything is fine, that our worries are over. They are not. This policy is effective only through next February, at which time we can only hope Integrity renews it again. What our recent experience tells us is that events seem to be beyond our control. Perhaps we will get coverage. Perhaps we will not. But it does not seem to make any difference how well we do our job, how much we limit our risks or how important our services are to the community. At the moment, it doesn't even seem to matter how much we are willing to pay for coverage.

If the Clinic is once again unable to find liability insurance next year, it will have two options: closing down, or operating without any coverage. To operate without insurance seems unconscionable, since to do so means exposing volunteers to potentially devastating liabilities. But closing the Clinic would represent a serious threat to the health of many of Prince George's County's working poor. These clients, like Mr. Stevens who you will hear from next, do not qualify for Medicaid, but are uninsured and have limited resources. At the Clinic, they are charged based on their income and family size. Without the Clinic, many of their health needs would go uncared for. There is only one clinic, on the other side of the County, that provides similar services at a cost our clients can afford. Many of our clients would find that clinic inaccessible. Children like Mr. Stevens' son would be left with no place to go unless they have life-threatening illnesses.

I hope this has helped you understand the impact the current malpractice crisis has had on this Clinic and many others like it. If we and other Clinics across the country are forced to close our doors, not only will individuals suffer, but so will the nation as it ultimately will pay the price both morally and financially. Thank you.

QUESTIONS FOR JULIA DOHERTY
Panel One

Q. DO YOU RECEIVE FUNDS UNDER THE COMMUNITY HEALTH CENTERS PROGRAM AUTHORIZED BY THE PUBLIC HEALTH SERVICE ACT?

A. No. The Clinic is supported in large part by the United Way. We also receive funds from the County Health Department, The Boeing Employees Good Neighbor Fund and from client fees.

Q. YOU SAID THAT YOU WERE TOLD BY YOUR INSURER THAT THERE WAS A MORATORIUM ON COMMUNITY HEALTH CLINICS. WERE YOU GIVEN TO UNDERSTAND THAT THIS MORATORIUM WAS DECLARED BY YOUR INSURER ONLY, OR WAS IT MORE WIDESPREAD?

A. We were told by many insurance agents that there was a widespread moratorium on insuring community health clinics. Integrity Insurance Company, following the cancellation notice they sent the Clinic, told us they were "no longer writing this class of business." As I mentioned previously, at a later date they decided against cancelling our policy and instead renewed it at a lower premium.

Q. DO YOU HAVE ANY FURTHER INFORMATION, OR WERE YOU GIVEN ANY FURTHER INFORAMTION, ON THE REASON FOR THIS MORATORIUM?

A. I was told the moratorium was in effect for a number of different reasons, including the high risks and potential losses associated with insuring Clinics. Our clinic, however, does not provide what are normally considered high-risk services. We do not provide prenatal or obstetrical care, nor do we perform any surgery. In over fifteen years of service, the Clinic has never been sued.

Senator **Metzenbaum**. Mr. Chairman, I would just like to say to you that this obviously, if it is not a conspiracy, it is a united effort on the part of the insurance industry in this undertaking. And I do not think any of us want the Government to go into that business. But I think if you and Senator Kennedy and I started to work to put together a bill in order to put the Government in the business of providing insurance where it could not otherwise be obtained, my guess is there might be a good signal sent out to the industry, and maybe we could make some progress and would not have to do it.

The **Chairman**. Well, Senator, I agree that something certainly has to be done. I think we should hear testimony from more than just one company that reversed its position. But there is no question there is a big problem here, and something has to be done. And your testimony is very important to us.

I think one of the reasons your insurance was renewed is because you put pressure on the State insurance commissioner, too, and you let him know this was a terrible thing, didn't you?

Mrs. **Doherty**. We did ask them to investigate our original cancellation notice, and they did determine the cancellation notice was invalid and said that the company should have given us 45 days.

The **Chairman**. I see.

Mrs. **Doherty**. Now, I cannot honestly tell you what made the company change their decision. There were a number of articles in the paper. There were several television reporters calling them. I am sure that the investigation might have affected it in some fashion. But I really do not know what made them change their minds. And in fact, they did not renew the policies for several of the other clinics that were in the same situation.

The **Chairman**. Well, I want to commend your center for really caring on a volunteer basis for the health needs of the low income and the impoverished. I think that what you are doing is commendable and I certainly believe that the Prince Georges Volunteer Health Clinic is doing a necessary job for people like Mr. Stevens and his son, John, and for people who might not be able to afford adequate health care.

Do you have any confidence that you are going to be able to get insured again in 1987, or are you anticipating the same problem you had this year?

Mrs. **Doherty**. I have no reason to believe that the situation will be any better next year. I would like to think that the impact of efforts at the State level and at the Federal level might change things, but I do not think I can operate under the assumption that that will be the case.

The **Chairman**. Yes. If you are unable to obtain insurance coverage this next year, then what will you do?

Mrs. **Doherty**. We have two options. One will be to close down, and people like Mr. Stevens and his son then would not be able to receive the care. And the other option would be to go ahead and operate without any insurance coverage.

The **Chairman**. And that exposes everybody who works there, including your board of directors and people who are volunteering their services, to possible lawsuits, with defense costs, attorneys' fees, and maybe even judgment costs.

Mrs. **DOHERTY**. Exactly. And if we ever were sued, which is very unlikely given our history and the clients that we are dealing with, then of course we would have to close down in that event, even if it was a suit that was totally unjustified, simply for defense costs. They would wipe us out.

The **CHAIRMAN**. Sure. Well, that is not a very good option for you.

Mrs. **DOHERTY**. Neither are very good options.

The **CHAIRMAN**. And then the community would lose a tremendous resource, it seems to me.

Let me turn to Senator Kennedy.

Senator **KENNEDY**. Well, you make some very important and valid points. This is another example where the lack of experience rating is reflected in a very real way in terms of the availability of quality health care.

I think you have indicated to us that you have had a very solid record of performance—over how many years?

Mrs. **DOHERTY**. Sixteen.

Senator **KENNEDY**. Sixteen years. And yet you are hit with this additional kind of a premium, even though you have had a very, at least from the record, what appears to be a very impressive record in terms of quality care.

Let me ask Mr. Stevens a question. What does the center mean to you and to your neighbors? How important is it to you?

Mr. **STEVENS**. Well, when he first got sick—he has psoriasis, and he is going to have it for the rest of his life—I started taking him to D.C. General first. I went there twice, and they told me that I did not live in the District, so I could not bring him there anymore. I do not have insurance.

What they were doing was writing me prescriptions to cure this, or to make it go away, but instead, it just kept growing, and now, it is all over his body, from his ankles all the way up.

And I started looking for another place to go. When I found this clinic, they gave me something that it is doing a whole lot better now.

But if this clinic goes—I do not have any insurance—if they turn me away anywhere else I go, I have got to go to another hospital, and I figure they are going to turn me away, too, because I do not make a lot of money and do not have insurance.

The **CHAIRMAN**. Let me just bring out one thing that is important. You are a hard-working man; you work as a laborer, is that right?

Mr. **STEVENS**. Right, yes, sir.

The **CHAIRMAN**. And you make just enough money that you do not qualify for Medicaid.

Mr. **STEVENS**. Right.

The **CHAIRMAN**. And yet you do not make enough money to be able to provide the necessary insurance or pay for it to take care of your son.

Mr. **STEVENS**. Right.

The **CHAIRMAN**. Or to even pay his doctor bills at regular office calls.

Mr. **STEVENS**. Right.

The CHAIRMAN. So that is one of the problems you have, isn't it; so you have to have a volunteer clinic like this to help your son.

Mr. STEVENS. Right. That is correct.

The CHAIRMAN. Thank you.

Senator KENNEDY. Well, I really appreciate what you have said. As the Chairman has pointed out, there are millions of Americans like you. The number of uninsured Americans has increased 43 percent in the last 5 years, due to a variety of different factors, but that is 39 million men, women, and children like yourself—the population of all of New England and New York State that are at risk. It is a real mounting crisis in our society, and we have attempted to address that particular issue in other legislation, but I think it must be extraordinarily nerve wracking for you.

I suppose one of the things you wonder every day is whether that clinic is going to be there.

Mr. STEVENS. That is right.

Senator KENNEDY. And you do not put a dollar-and-cents sign on that. That is real anxiety in terms of your children.

Can we ask your son a question?

Mr. STEVENS. Yes.

Senator KENNEDY. Do you prefer going to the clinic? Do you like going to the clinic?

Mr. STEVENS, JR. Yes.

Senator KENNEDY. Are they nice to you there?

Mr. STEVENS, JR. Yes.

Senator KENNEDY. Are all the nurses and doctors nice to you?

Mr. STEVENS, JR. Yes.

Senator KENNEDY. Do they give you the medicine there, too?

Mr. STEVENS, JR. Yes.

Senator KENNEDY. Are you feeling better since you have been going there?

Mr. STEVENS, JR. Yes.

Senator KENNEDY. And you want it to stay open, too?

Mr. STEVENS, JR. Yes.

The CHAIRMAN. Well, he has the best grin of anybody I know. Next witness——

[Laughter.]

Senator KENNEDY. Well, we are very glad to have you here, and glad you are doing well.

The CHAIRMAN. Yes, we really are.

Senator Metzenbaum.

Senator METZENBAUM. Mrs. Doherty, give me a little better picture of the clinic, if I may. You have six doctors, do you, on staff?

Mrs. DOHERTY. We have four doctors on staff. They all receive a small stipend. Each of them only works there one night or day a week, for a small stipend. And in fact, if we were to lose our insurance, one of those physicians only has insurance connected with the hospital. We would also then be asking him to work in the clinic bare, without any insurance at all.

Senator METZENBAUM. Are they all general practitioners, or are there any specialists?

Mrs. DOHERTY. There are two gynecologists—one is a pediatrician. And the other one is a doctor of internal medicine. However, the care that is provided by gynecologists could be provided by family practitioners. As I said, they are not providing obstetrical care at all; it is simple primary care, including GYN exams.

Senator METZENBAUM. Mr. Stevens indicated that there has been considerable improvement with John and his psoriasis. Do you have access to specialists for, for example, cases such as psoriasis?

Mrs. DOHERTY. Well, fortunately—I cannot speak specifically to their case—but in general, our pediatrician has very good relations with the people at Children's Hospital. He also has his own private practice. And in the instances where we do need to make referrals for children for specialty care, Children's Hospital downtown has been very helpful.

Unfortunately, the same situation does not apply to adults. We have a very difficult time referring people who need specialty care who are adults.

Senator METZENBAUM. Most of your funding comes from where?

Mrs. DOHERTY. Sixty percent of it is the United Way; another 20 percent is from the county, and the difference is made up with assorted grants and with charges, the fees that we charge to clients.

Senator METZENBAUM. And what is your total budget on an annual basis?

Mrs. DOHERTY. A little over $100,000 a year.

Senator METZENBAUM. Incredible.

Mrs. DOHERTY. We serve a little over 2,000 patients in a given year.

One thing that I think is particularly important to keep in mind here is that we are not an isolated clinic. Although we are isolated to a certain extent in the county, there are not many of us. There are community health clinics all around the country that are facing the exact same problem connected to insurance. And I do not think any of them have been able to find solutions any better than what I have found, which is to try every, single angle, and hope that something comes through.

I was holding my breath until the last minute, and I still cannot explain why it worked or what happened, except that fortunately we have now until next February 14.

Senator METZENBAUM. John, could I ask you a question?

Mr. STEVENS, JR. Yes.

Senator METZENBAUM. Would you rather be here before this Senate Committee or watching a good basketball game? [Laughter.]

You can answer.

The CHAIRMAN. John, do not let him bait you like that. [Laughter.]

All right. Senator Thurmond, do you have any questions?

Senator THURMOND. Mr. Chairman, I have a statement I would like to make, and then I have another appointment.

The CHAIRMAN. Fine. Senator, if you could just wait for one second, I will button this testimony down, and then turn to you; is that all right?

Senator THURMOND. Fine.

The CHAIRMAN. Let me just finish this testimony.

Did you have any questions, Senator Nickles?

Senator NICKLES. No; I have none.

The CHAIRMAN. Let me just ask two questions, then.

Mr. Stevens, as I understand, at Prince George's Volunteer Clinic that we have been discussing here today, you pay about $15 per visit, is that right?

Mr. STEVENS. Ten.

The CHAIRMAN. You pay $10. That is contrasted to what amount if you went to a doctor's office?

Mr. STEVENS. Well, I took him twice to D.C. General, and I think the bill was $78.

The CHAIRMAN. For each time, or——

Mr. STEVENS. No; They sent it all in one bill.

The CHAIRMAN. So you are saying almost $40 per visit, otherwise?

Mr. STEVENS. Right.

The CHAIRMAN. So if you can go to Prince Georges Volunteer Health Clinic with John's problem, that would save you a considerable amount of money each year?

Mr. STEVENS. Oh, yes.

The CHAIRMAN. And as I understand it, you have a pretty tight budget, because you make what, about $13,000 a year?

Mr. STEVENS. Something like that.

The CHAIRMAN. Like I said, a little bit too high for Medicaid coverage, but a little too low to be able to afford insurance. There are just really millions of people in this country who fit in that category, who are hardworking, honest, decent people like yourself who want to work and do not want to be dependent upon anybody else, but yet who still fit in that category where they are hardworking and earning what they can, but still, it is not quite enough to be able to take care of a problem like John has, here.

OK. Let me just say this. I want to tell you that we respect you, and we respect the problems that you have, and we will just have to see what we can do about those. We certainly, Mrs. Doherty, respect your problems.

We hope we can come up with some answers here that will be societal and beneficial, and we will see what we can do.

Yes?

Mrs. DOHERTY. I would just like to add one thing related to the costs. The other cost that Mr. Stevens would have to contend with would be the cost of prescriptions. A lot of the clinics do get donated pharmaceuticals when possible. In fact, some of the medication that the child received for psoriasis was donated medication, and there was no charge for that. It was included in the $10 fee.

The CHAIRMAN. OK. Well, John, we want to tell you it has been nice to have you here. You are a fine-looking young man, and we hope you can get the kind of medical care that will keep you looking so good.

Senator KENNEDY. Mr. Chairman, let the record also show that the two babies are sleeping. So our panel has been able to put them to sleep. [Laughter.]

The CHAIRMAN. Well, I do not know that it is the panel, myself.

Senator KENNEDY. I mean our panel.

The CHAIRMAN. Yes; this committee has been known to do that in the past.

With that, we want to excuse you folks and thank you all very much for appearing. It has meant a lot to us to have you here, and thank you for coming. We appreciate it.

Senator KENNEDY. Thank you very much.

The CHAIRMAN. We will turn now to Senator Thurmond.

Senator THURMOND. Mr. Chairman, first of all, I would like to commend you for holding hearings on this very complex and important issue.

I have heard from many with diverse views regarding this issue of national scope. In addressing this problem, any solution fashioned—whether by State legislatures or by Congress—must consider the views of all parties affected by medical malpractice. Therefore, I feel these hearings are timely and will be helpful in identifying the problems associated with this issue.

Health care providers, the insurance industry, lawyers, and victims of medical malpractice, each have their own point of view, not only of the causes of the problems, but also of the scope.

The health care community is concerned about the increasing cost of health care resulting from medical malpractice lawsuits, which ultimately must be passed on to the public. Physicians are concerned about having to practice defensive medicine, where they must order tests not normally needed to avoid potential criticism in the event of an unsatisfactory result.

The American Medical Association estimates that an additional $15 billion a year is added to the cost of health care because of this practice.

Another cost associated with medical malpractice is the payment of physicians of over $4 billion a year in professional liability insurance. Doctors are also concerned about the increasing prospects of a long, drawn-out malpractice trial and its effect on their practice and family life, even if they are exonerated, as they are 75 percent of the time.

The concerns of the insurance industry must also be addressed. The industry has pointed out that in 1984, it suffered an underwriting loss on policies of more than $20 billion. In addition, some would say that sympathetic juries, overwhelmed by persuasive lawyers, have awarded undeserved millions of dollars in damages. Insurance spokespersons cite figures from studies which indicate an average award in malpractice cases of $950,000, and 360 verdicts in 1983 of more than $8 million.

In addition to the views of health care providers and the insurance industry, the legal profession has expressed its concerns. Lawyers have cautioned against interference with the jury process. Reminding us of our cherished right to a jury trial handed down since Magna Carta, the legal profession has pointed out that the jury has been the counterweight to the arrogance, prejudice, tyranny, ignorance and plain dishonesty of abusive governments, and the rich and powerful.

Proposed restraints on the jury process should be closely examined.

Attorneys have also cited a major new study of court filings in 25 States by the National Center for State Courts. According to the report, in most courts surveyed, litigation actually declined between 1981 and 1984. In addition, in my home State of South Carolina, the Trial Lawyers Association concluded from its study that the average malpractice claim amounted to approximately $8,000.

Finally, as we examine all of the issues associated with medical malpractice, we must not forget the rights of malpractice victims. Unfortunately, and despite the fact that America has the best health care in the world, malpractice does occur. We must ensure that victims suffering from negligent care causing such conditions as permanent paralysis, permanent brain damage, or any number of medical problems, are fairly compensated.

Thus, medical malpractice poses complex and difficult problems. It is my hope that this hearing and others, if others are to follow, will shed some light into this area and help to show how best to balance these various competing interests.

I regret that other duties of the Senate require that I leave at this time, but I look forward to reviewing the testimony presented today.

Mr. Chairman, I want to take this opportunity to welcome Dr. Roger Gaddy, of Winnsboro, SC, who I understand is testifying at this hearing. I understand he is going to make certain points that because of the high risk of liability insurance, he has left the field of obstetrics and now only practices family medicine.

Now, the people in that area must send pregnant patients 40 miles for delivery, which is a lot of travel for pregnant women.

Dr. Gaddy, we are very pleased to have you here, and I am sure your testimony will be a great addition to the hearing.

Dr. GADDY. Thank you, Senator.

Senator THURMOND. Mr. Chairman, this whole field is extremely important. A good many obstetricians now—I have a nephew now who is an obstetrician, and I did have two brothers who were obstetricians; one is retired now, and the other has passed on. I have other doctors in my family. I know the insurance they have to pay has just become outrageous, not only for them, but other doctors.

Here is a man who has had to quit practicing his specialty, which he has practiced for years. He went to college and trained to become skilled in his field. He has had to give it up and go into family practice for fear of the lawsuits that might result; that is a pity.

I do think that steps must be taken to protect the public; steps must be taken to make liability insurance more reasonable. At the same time, we have got to consider that the victim, if he is really damaged, is entitled to be compensated.

So that is the reason I say it is such a complex field and deserves the utmost consideration from this committee, and the advice of all these people who are testifying I am sure will be very helpful.

Mr. Chairman, again, I thank you for holding these hearings and trying to get to the bottom of this situation, with the hope that a fair, honest and reasonable solution will result.

The CHAIRMAN. Thank you, Senator Thurmond. We appreciate it.

Senator NICKLES. Mr. Chairman.

The CHAIRMAN. Senator Nickles.

Senator NICKLES. Mr. Chairman, I likewise will follow Senator Thurmond and compliment you on this hearing. I have conducted similar hearings in my own State of Oklahoma. We, like every State in the Nation, have some very serious problems with the impact of the liability crunch in the medical profession. It affects many industries, but is hitting the medical industry particularly hard. I think it is important to examine the impact that this is having on the quality of health care provided throughout the Nation.

For the most part, I think you will find the impact has been very negative—negative from the standpoint that Senator Thurmond mentioned; he talked about physicians leaving particular types of practice in various areas. We have had the same thing happen in my State. If you have fewer medical personnel practicing or avoiding practicing obstetrics or gynecology, for example, just because the insurance is not affordable, that means that care is not being provided, or that only a small number of people providing care.

In the case of obstetricians, in some areas of my State, similar situations have occurred that a gynecologist or an obstetrician is not in the area, and therefore the patients have to commute on a roundtrip basis of 80 or 90 miles for services. Time is important, of course, and it may cause some very serious problems for those individuals.

The cost is certainly a problem. The cost of defensive medicine, a good percentage of which is subsidized by the Federal Government. Also, a good percentage of which is borne by the patients, insurers, and the entire medical field.

So we have some very serious problems. I also would echo the comments of Senator Thurmond, that we also have the rights of those persons who are injured through some type of accident or other, they need to be rightfully compensated. So this is a very complicated issue, one that I compliment you on taking the leadership to address this issue in your bill. I think it is a step in the right direction. At least it pulls the Senate into examining this issue. It may not be the correct answer for all the problems, I do not know, but at least it is a focal point for us to begin looking and hopefully see if we can come up with some positive remedies to some very difficult questions.

The CHAIRMAN. Well, thank you, Senator Nickles.

Our second panel today will focus on the withdrawal of services that have taken place in the field of obstetrics because of the malpractice insurance crisis.

Our witnesses on this panel include Dr. Mary Raum of Ocala, FL; Dr. Roger Gaddy of Winnsboro, SC; Deneen Rydland, Petersburg, WV; and Howard McQuarrie of Salt Lake City, UT, on behalf of the American College of Obstetricians and Gynecologists. The others will be speaking as individual practitioners.

So, Dr. Raum, we will begin with you. Again, I call your attention to these lights. We are going to limit you to 5 minutes. We will put your full statements in the record, but I am going to cut you off after 5 minutes so I can get through all these witnesses today, if we can.

Dr. Raum.

STATEMENT OF DR. MARY E. RAUM, OCALA, FL; DR. ROGER GADDY, WINNSBORO, SC; DR. DENEEN RYDLAND, PETERSBURG, WV, AND DR. HOWARD G. McQUARRIE, SALT LAKE CITY, UT, ON BEHALF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. RAUM. Thank you very much, Senator Hatch.

My name is Mary Raum, and I am from Ocala, FL, and I am a gynecologist. Until about 4 months ago, I could have also said I was an obstetrician. But due to the high cost of liability insurance, I have been forced to stop that portion of my practice.

I have only been in practice since July 1983. I am an honor graduate of a well-respected medical school in the United States. I completed a residency program in an outstanding university residency, and I have never yet been involved in a malpractice suit.

But my rates for insurance have gone from $2,000 the first 6 months to $11,000 in 1984; $32,000 for 1985, and in December, just before Christmas, I got a bill for close to $50,000—for half the amount of insurance that I had the year before.

I was left with the choice of either increasing my rates substantially and increasing the number of patients I see, or giving up this portion of my practice.

There is no way as a solo practitioner that I can increase the number of patients. And I could not see increasing the costs to my patients. I do live in an area, also, where salaries are not high. We are in a little enclave of Florida where many people still make minimum wage. The average salary for a family of four is less than $20,000.

Giving up obstetrics is upsetting to me. It is traumatic when a woman you have cared for, someone who has had an infertility problem, becomes pregnant, and then you have to tell them you are not going to take care of them and transfer them to someone else.

When they do see someone else for care, the average cost now for a routine, uncomplicated delivery is going to be about $1,200. That has increased from around $500 just 4 years ago in this area.

The obstetricians in our town do still deliver emergency patients. They come in with little or no prenatal care. And this also is slowly increasing as the cost of that care goes up and as the number of obstetricians is going down in Florida.

Trying to figure out how to pay these bills is very disturbing. But perhaps just as bad is the spectre, the threat of litigation.

Yes, there are bad doctors. Yes, there is malpractice. But more often, there is just a bad outcome.

But I read the other day in one of our journals something that was really—terrifying is a good word. Commenting on the malpractice situation someone said, "If you practice good obstetrics and have a good outcome, you are OK. If you practice good obstetrics and have a bad outcome, there will be a suit."

No matter how careful and how conscientious the obstetrician, there are going to be bad outcomes. Yet in today's climate, if there is a suit, it is on the assumption that if something is wrong with the baby, the obstetrician must have made a mistake. This is unfair, because rarely can fault be determined. But when a jury sees an abnormal or a severely handicapped child, the impulse is to try to recompense these parents and recompense these children.

Many of these emotionally based settlements run into the millions. There is no way any obstetrician anywhere can afford insurance that would cover a multimillion dollar settlement.

We are only human. This threat hovers over every encounter with a patient, no matter how I might try to push it away. And therefore, defensive medicine is practiced.

You will hear some people counter that defensive medicine is good medicine. It is certainly expensive. Physicians must choose between doing what we really truly consider to be logical, reasonable and cost-effective in a particular instance, versus covering every possible contingency, no matter how unlikely.

The liability problem, however, does not just affect my obstetric patients, but my gynecologic patients. Intrauterine devices are no longer available as an option for appropriately selected women in this country. The Copper-7 was recently withdrawn due to the high cost of defending liability suits.

A significant number of women have thus been deprived of a successful and very acceptable method of contraception because and only because of the liability crisis.

The children of my patients may be in danger of losing certain vaccines because of the high cost of liability insurance for the manufacturers of these vaccines. I recently found out when I tried to get a patient of mine a consult for severe back pain that most of the orthopedists in my town will no longer accept a patient who has neck pain or back pain; they have dropped that portion of their practice because of the liability crisis.

All specialties and all patients are affected.

You are going to hear a lot of testimony from experts in legal matters and experts in insurance matters. They will be able to discuss the merits of the various measures before you. I am here today to tell you there is a problem.

Thank you.

The CHAIRMAN. Thank you so much, Dr. Raum. And I appreciate you finishing on time. That was eloquent testimony.

[The prepared statement of Dr. Raum follows:]

Testimony of

MARY E. RAUM, M.D., P.A.
GYNECOLOGY

Before the

COMMITTEE ON LABOR AND HUMAN RESOURCES

May 7, 1986

Ladies and Gentlemen of the Committee:

I appreciate being allowed to speak today. My name is Mary Raum. I am from Ocala, Florida and I am a gynecologist. Until 4 months ago I could have told you that I was an Obstetrician and Gynecologist but because of the high cost of malpractice insurance in my state, I have been forced to give up the practice of Obstetrics.

I have only been in practice since July of 1983. I returned to college and medical school after establishing my family. My husband and daughter made many sacrifices so that I could complete a residency in Obstetrics and Gynecology, one of the most time intensive specialties known. However, they were willing to work with me because they knew how much I loved it. Being allowed to assist in the birth of a child is one of the rare privileges in life. It is a unique experience and I know of nothing else in medicine that can truly compare. Therefore, the necessity to give up this practice both angers and grieves me.

When I first started practice, I obtained malpractice coverage with an insurance company that would allow me to gradually increase my premiums based on the fact that I was just starting practice. It was understood that the premiums would increase somewhat per year but that over and above the expected increase would be the unknown increases for losses that needed to be covered by the company. The first six months of practice I paid a litle over $2,000 for $1,000,000 worth of insurance. The next year I paid $11,000 for the same coverage. The following year I paid $31,000 for the same amount of coverage. This was prohibitive for me, so I dropped my coverage in half and still had to pay some $26,000 for malpractice insurance coverage last year. In December of 1985 I received a bill for over $49,000 for $500,000 worth of malpractice coverage for 1986. There is no way working as a solo practitioner and delivering the kind of care that I want to deliver, that I can pay that kind of rate. I would be forced to either raise my rates to my patients, something they cannot afford, or to markedly increase the number of patients that I see per day, something that I cannot in good conscience or for the sake of good medicine do. Therefore, the practice of Obstetrics has become a luxury I cannot afford. It would be easy if one could simply say "I'm giving up Obstetrics." Unfortunately, placing a notice on the office wall doesn't begin to accomplish this. Every time a woman I've cared for becomes pregnant then I must refer her to someone else for obstetric care.

This is a loss for me and a loss for my patients. Those that I have already delivered have frequently cried and I've cried with them. Others have asked to sign agreements not to sue if I'll only agree to deliver them.

When these patients go to another physician for care, they must pay somewhere around $1200 for prenatal routine care and delivery. This has increased from $500 four years ago. In our county many people still make minimum wage. It is one of the lowest paying counties in Florida but the cost of malpractice insurance is not based on this. Therefore patients must pay the same as if they were in metropolitan areas where salaries are much higher. The average income per capita is less than $14,000, the average income for a family of 4 is less than $20,000. Unfortunately, the people having babies are young people, many of whom have no insurance at all. The Obstetricians in our town deliver many women on an emergency basis who have received little or no prenatal care and simply walk into the hospital in active labor. I'm afraid that this is going to increase as the number of obstetricians decreases.

I live about 2 hours from St. Augustine, Florida, the oldest city in North America. As of July, there will be no routine deliveries in a hospital in that city. Neither the hospital nor the physicians could work out payment of the increased malpractice premiums of $232,000. Women from this town and indeed from that surrounding county must travel into another county for prenatal care and delivery. In my own area pregnant women from an adjacent county have to drive over 60 miles to obtain care. Most of the obstetricians in that area have given up this part of their practice directly due to the cost of malpractice insurance.

Trying to figure out how to pay these malpractice bills is devastating. Perhaps even more disturbing to the physician is the constant threat of litigation. Yes, there are bad doctors. Yes, there is malpractice but much more often there is simply a bad outcome. I recently shuddered to read in one of our specialty journals a comment that "if you practice good obstetrics and have a good outcome you are o.k., if you practice good obstetrics and have a bad outcome, you will get sued." This is terrifying. The implication, indeed, the actuality is that no matter how conscientious the obstetrician there will be unavoidable bad outcomes. Yet in today's climate a bad outcome in most instances is going to mean a suit because of the feeling that if there is something wrong with the baby the obstetrician must have made a mistake.

This is patently unfair, because rarely can a fault for the abnormality be determined. However, when a jury sees a malformed or severely handicapped child, the impulse is to try to recompense the child and the parents in some way. Many of these emotionally-based settlements run into millions of dollars. There is no way that any obstetrician can afford insurance that would begin to cover multi-million dollar settlements.

We are only human. This threat hovers over each encounter with a patient, no matter how we try to push it away. Therefore, so called "defensive medicine" is commonly practiced.

Defensive medicine includes the ordering of tests or procedures which have a low probability of yielding a positive result. It also includes counseling all patients as if they were at high risk for complications from procedures or conditions. The result is increased costs and unduly hightened patient anxiety.

Physicians and their patients are constantly torn, and we physicians must choose between doing what we consider logical, reasonable and cost-effective in a particular instance vs covering every possible contingency, no matter how unlikely. Perhaps, as some people claim, defensive medicine is the best medicine. It is certainly the most expensive.

One alternative I considered was to simply drop all malpractice insurance. However, the State Legislature in Florida has decreed that it is mandatory for physicians to have malpractice insurance by 1987. Other obstetricians in my town previously "went bare" as we call it. However, since the Florida Legislature is requiring that they begin to carry malpractice insurance next year, they will be forced to make the decision to either pay over $50,000 each for malpractice insurance or simply do as I did and give up the practice of Obstetrics. Who ultimately suffers? The patients! I am just one physician. I miss obstetrics. I mourn the loss of this part of my life but I'm just one. My patients are many and they are the ones who are being forced to fine obstetric care elsewhere, to seek new relationships, to put their trust with other physicians and to pay the high costs of obstetric care brought about by the current liability crisis.

Of course the liability problem involves not just my obstetric patients but the gynecologic patients also.

I can no longer place intrauterine devices in appropriately selected patients for contraception. The Copper 7 was withdrawn recently not because of any fault of the product but because of the high cost of defending litigation. A significant number of women have been deprived of a successful and very acceptable method of contraception because and only because of liability costs. The children of my patients may soon be unable to get vaccinations because of the costs of liability coverage for the vaccine manufacturers. Most of the orthopedic surgeons in my town will no longer see patients with back pain. All specialties, all patients are affected.

You will hear testimony from experts in the legal and liability insurance fields who will discuss the merits of various measures before you. My purpose in being here is to pursuade you that the need for tort reform is real.

In closing I deeply appreciate the opportunity to share these thoughts with you. I realize they have been very personal ones but I think that I represent the majority of physicians in my area and in my state. We wish to render good care. We are aware of the costs of medical care and yet we feel very threatened by the spectre of malpractice litigation. If costs keep rising, they must be passed on to the patient. Untimately the patient is the one who suffers; from the increased costs of medical care, the unavailability of care and from the effect on the patient/physician relationship.

Thank you for your attention.

The CHAIRMAN. Dr. Gaddy, we will turn to you now.

Dr. GADDY. Thank you, Senators. I certainly appreciate the opportunity to speak before you.

My name is Roger Gaddy. I am a 35-year-old Board-certified family practitioner, practicing in Winnsboro, SC, the county seat of Fairfield County.

Our 700-square-mile county is rural and poor, with the primary industry being the tile and wood products. Our hospital is licensed for 50 beds and has a Board-certified surgeon and Board-certified pediatrician on staff.

I, along with two other Board-certified family practitioners, until recently provided the only obstetrical care available in our county.

Approximately 9 months ago, my colleagues and I became concerned over the increased litigation in the field of obstetrics. Increasing publicity concerning the number of malpractice suits in Florida, New York, and California, and the magnitude of these awards made us acutely aware that the practice of obstetrics was the highest-risk portion of our family practice.

Realizing that most of the malpractice concerned OB-GYN specialists, I felt that it was not in my best interest to continue my obstetrical practice.

Many of the mothers that I delivered were followed at the local Health Department for their prenatal care and were seen by me only at the time of delivery. Because of their socioeconomic background, many of the mothers were noncompliant in their prenatal care, putting them and their infants at increased risks for complications.

Also realizing that I did not have an ongoing relationship with these mothers increased the possibility of litigation against me.

At 5:08 in the morning on February 25, I delivered my last infant at Fairfield Memorial Hospital, and thank goodness it was healthy.

Neither the cost nor the availability of malpractice insurance was a factor in my decision to discontinue obstetrics. My decision was based on the fear of litigation.

Arrangements were made for the County Health Department patients to be delivered in Columbia, at the University of South Carolina School of Medicine, Department of Ob-Gyn. Although this does afford patients high-quality care, it involves the added inconvenience and expense of traveling up to 45 miles for the delivery of their infants. Private patients also have to travel out-of-county for their deliveries.

Although 45 miles may not seem so great a distance, many of my patients do not have adequate transportation. Some have no transportation at all. Winnsboro is located in a rural, indigent county, and it is not uncommon for a lady to call the ambulance to transport her to the hospital whenever she feels her labor might be starting. The responsibility is then upon the county to transport her to one of their referral hospitals for delivery if indeed she is in labor. This puts an undue burden not only on the patient, but also on the county, for having to provide long-distance transportation for usually nonemergency problems.

The long-distance travel is also a burden for family members, limiting their availability for emotional support to the patient during this trying time.

I sincerely regret having to make my decision to discontinue obstetrics. I have enjoyed the experience of obstetrical care. Certainly, one of the most gratifying and pleasing experiences in medicine is the delivery of a healthy baby. Most woman have a limited disease: It lasts for 9 months and has a positive outcome.

Unfortunately, Mother Nature is not perfect, nor are human beings. And in that rare instance when a less-than-perfect infant is born, it is difficult for the parents to accept. The natural reaction is to ask, "Why did this happen to me?" At that point, it is imperative for them to have someone other than themselves to blame for this less-than-perfect child. Generally, it is the doctor whom this frustration and anger is directed toward.

Subsequent to my decision to discontinue obstetrics, I have apologized to my patients who desire local delivery. I have explained to them that because of the increased litigation surrounding obstetrics, that it is no longer feasible for me to continue bringing babies into the world.

The **CHAIRMAN**. Thank you very much, Dr. Gaddy.

We will turn to you now, Dr. Rydland.

Dr. **RYDLAND**. Mr. Chairman and members of the committee, I appreciate the opportunity to speak to you all today as a physician providing care in West Virginia.

I am the only obstetrician in a small town, Petersburg, WV, and I have been there since 1984. I am presently fulfilling a National Health Service Corps obligation by serving in a medically underserved area.

Before I came to Petersburg, women had to travel about an hour and a half over several mountains in order to receive care. Care was only available in Maryland and Virginia.

I provide several types of care as most obstetricians do, including routine and high-risk prenatal care; deliveries; obstetrical and gynecologic surgery; emergency obstetrical and gynecologic care, as well as preventive care, and education about women's health.

I provide the childbirth classes to my expectant parents free-of-charge, and I do do a lot of teaching in the local junior high and high school.

The eastern panhandle of West Virginia has an unemployment rate of about 14 percent. Therefore, my practice cares for a large percentage of indigent and low-income patients. Approximately 15 percent of my patients as opposed to 10 percent at the State level are covered by Medicaid. In my obstetric practices, this is closer to 30 percent. And this has increased in the last 2 months because of the discontinuation of obstetric services—to Medicaid patients only—in Cumberland, MD because of malpractice concerns.

I also participate in maternity care through the State Program for Maternal-Child Health, and this covers the so-called "working poor." I am the only obstetrician taking care of these patients for a five-county area. At the present time, this is over 30 percent of my obstetrical practice. Without this program, many of these women would not obtain care, thus incurring all the increased risks that you have heard about today.

I also participate in several other public assistance programs including Medicare, Statewide Family Planning, and Vocational Rehabilitation.

On March 8, 1986, in West Virginia, senate bill 714 was passed by the legislature. On April 8, malpractice insurance for physicians was canceled by three of the four insurance carriers in West Virginia. This was initially supposed to happen on May 11, but the deadline has been extended to May 31 to allow the legislature to meet after our May 13 primary.

If malpractice is terminated in West Virginia, there will be severe effects on the health care provided in my region of the State. Nine of the twelve doctors in Petersburg that admit patients to the hospital will no longer have coverage and may have to discontinue care. This includes our emergency room doctors, our general surgeon, our pediatrician, and three of the five family practitioners, as well as myself. The only practitioners who will be able to supply care are two of the family practitioners and the internist.

Eighty-five percent of our nurses will be without malpractice insurance, and no coverage to provide in-hospital emergency or office care.

Our hospital had its coverage canceled, which means we will not be able to provide laboratory, x ray, surgical, medical, pediatric, emergency, or obstetrical care.

At the present time, the ambulance service still has malpractice coverage, so we will be able to transport patients who are ill to other States for care.

Senator METZENBAUM. Dr. Rydland, you talked about the West Virginia legislature and its action. I am not sure if you explained what that action is. Maybe you did, and I missed it.

Dr. RYDLAND. The legislature passed a bill on March 8. It is called senate bill 714, and I do not have the complete text of that bill. In my testimony, I have included the letters from my malpractice insurance company, stating that they are terminating malpractice coverage in West Virginia.

Senator METZENBAUM. I guess what I am really asking is what does the legislation do that is causing the insurance companies to cancel?

Dr. RYDLAND. The malpractice insurance companies did not make that terribly clear to me in the letters that they sent us. And that is something that you probably will have to address with the malpractice people, because I do not understand it myself.

Senator METZENBAUM. All right. I do not mean to interrupt your testimony, but I just was not clear what the cause and effect is.

Dr. RYDLAND. I really do not know specifically——

Senator METZENBAUM. You know the effect.

Dr. RYDLAND. I know I am affected, that is right.

I presently have 91 pregnant patients, 75 of whom are expected to deliver after this insurance deadline. Over 50 percent of these patients are in the low economic groups, either Medicaid or through our Maternal-Child Health Program. Either they would not be able to afford care, or it would not be available within a 2-hour distance.

These patients are concerned about whether or not they are going to have care, and a lot of these patients do not go to see a doctor unless there is someone in the local area.

I am concerned about whether I can continue to provide service in West Virginia. I have never had a malpractice suit filed against me, and yet my malpractice insurance jumped fourfold from 1984 to 1985.

The CHAIRMAN. What is your present cost now for malpractice insurance?

Dr. RYDLAND. This last year my malpractice insurance was $13,241. They told me that it would probably double in the next year—if I could get it, which I cannot—and not being able to have malpractice insurance, I also have to buy what is called "tail coverage", which means that you buy coverage retrospectively to cover anything that you have done up to the point when your insurance is canceled, which would probably run about $41,000 as a lump sum.

The CHAIRMAN. Well, thank you. We appreciate your testimony.

Let us turn to you, Dr. McQuarrie.

Dr. MCQUARRIE. Thank you, Mr Chairman and members of the committee.

I am Howard G. McQuarrie, M.D., a practicing gynecologist from Salt Lake City, UT. In addition to my specialty practice, I am chairman of the Utah Physicians Licensing Board and president-elect of the Federation of State Medical Boards.

Today I am here representing the American College of Obstetrics & Gynecology, an organization of 25,000 physicians specializing in the delivery of health care to women.

I am pleased and honored to have this opportunity to speak to you about an issue of overriding concern to the members of our specialty—that is, the high cost and unavailability of professional liability insurance and the disruptive impact this has on patient access to health care.

It has never been safer for a mother to have a baby in the United States. It has never been more risky for a doctor to deliver one. The problems of liability threaten to destroy both physicians and the quality of medical care.

Our surveys show more and more physicians are leaving obstetrics because of fear of lawsuits, or because they are unwilling or unable to pass on the real costs of liability to their patients.

Family physicians who deliver babies and nurse-midwives are also affected by the crisis. As a result, in some parts of the country, it is hard to find someone qualified by modern medical standards to deliver a baby.

Nationally, for the past 2 years, premiums for our specialty have doubled. In Broward and Dade Counties in Florida, obstetrician-gynecologists pay between $82,000 and $118,000 a year just for liability insurance.

In Virginia, physicians cannot open solo practices because they cannot get insurance. West Virginia will be virtually without insurance by the end of this month, as has been described by Dr. Rydland.

As a result of the liability pressures, 12 percent of the fellows of the college in 1985 had discontinued obstetrics; in Florida, one out of four have.

The same surveys show that 73 percent of obstetrician-gynecologists have been sued at least once; 30 percent, two or three times in some parts of the country.

If medical care was getting worse, these statistics would not be surprising. In the face of the remarkable accomplishments of medicine, it is a profound irony, indeed: Infant mortality is down; maternal mortality is down; lawsuits are up.

In those few instances where a physician is incompetent or impaired, he or she should be removed from practice. But do not be misled. The crux of the problem is not physician incompetence. It is the breakdown of the traditional liability insurance system. Let us not be blameful of just insurance companies or lawyers or bad doctors or the public. All parties need to work toward a responsible solution to what bas become a societal problem.

The Federal Government must assert its role in developing model solutions.

We commend Senator Hatch for introducing a bill to address and, hopefully, begin to solve this problem. If all the tort reforms of S. 1804 were adopted in the 50 States, there would be a positive impact on the problem. The tort system often takes 2 to 5 years to resolve cases and pays less than a third of the premium dollar to injured parties. This is unacceptable and will destroy the fundamental concept of justice.

While the college supports efforts such as those contained in S. 1804 we are convinced the problem will not be fully solved until alternative dispute resolution mechanisms are available.

The ACOG has endorsed S. 1960, introduced by Senators Durenberger and Danforth, and pending before the Finance Committee. This bill promises prompt payment to injured parties with a significant reduction in costs associated with settling claims.

It will reduce the tensions between physicians and patients. The prompt payment mechanisms of S. 1960 has several features similar to the tort reforms contained in S. 1804, such as reducing awards by amounts received from other sources and payment of future damages in periodic payments.

The American College of Obstetricians & Gynecologists urges the committee to give serious consideration to alternative dispute resolution systems.

We appreciate the efforts of the chairman and the committee and commend you for acknowledging that this problem is national in scope. We look forward to working with you, and I would be delighted to answer any questions you may have.

Thank you.

The CHAIRMAN. Thank you so much.

[The prepared statement of Dr. McQuarrie follows:]

STATEMENT
of the
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Presented by
Howard G. McQuarrie, M.D.

on

MEDICAL MALPRACTICE INSURANCE

before the
Committee on Labor and Human Resources
United States Senate

May 7, 1986

Mr. Chairman and Members of the Committee, I am Howard G. McQuarrie, M.D., a practicing gynecologist from Salt Lake City, Utah. I am representing The American College of Obstetricians and Gynecologists (ACOG), an organization of more than 25,000 physicians specializing in the delivery of health care to women. The College is pleased to have this opportunity to speak to you about an issue of overriding concern to physicians, and in particular to members of our specialty: the high cost and unavailability of professional liability insurance and the impact this has on access to health care.

It has never been safer for a mother to have a baby in the United States than today. And it has never been more risky for a doctor to deliver one. Today more and more physicians are discontinuing obstetrical practice because they are unable or unwilling to pass on the high costs of liability insurance to their patients. Some patients pay more than $850 of their obstetric fee just for the cost of professional liability coverage. Some doctors who want to set up practice literally cannot get insurance at any price. There is an increasing tension and growing distrust between patients and physicians. None of these developments contribute in a positive way to the healing process.

COST AND AVAILABILITY OF INSURANCE

The traditional professional liability insurance system is breaking down and the resulting crisis threatens access to maternity care. Nationally, in the past two years, premiums for obstetrician/gynecologists have doubled. However, national statistics do not tell the whole story. In 1985, premiums for $1 million worth of coverage ranged from a low of $6,200 in Arkansas to a high of $72,000 in New York. Rates in 1986 for the same $1 million worth of coverage are as high as $41,800 in California, $58,000 in Michigan and $118,000 in Florida. Annual percentage rate increases have also been dramatic: 65% in Colorado, 81% in Montana, and 88% in Utah. In the last fifteen months, obstetrician/gynecologists in the state of Missouri have faced a 207% increase in liability premiums.

The increasing cost of obstetrical liability insurance also affects other physicians and their patients. For example, in Florida most family practitioners whose practice includes obstetrical care pay the same premium for liability insurance as obstetricians. One third of family doctors in California, whose practices had included obstetric services, no longer provide obstetric care. One half of family physicians in rural Nevada stopped delivering babies as of April 1, 1986.

Situations now exist where insurance is not available at any cost. As of the first of this year, the St. Paul Fire and Marine Insurance Company (St. Paul), the largest commercial carrier for medical malpractice insurance, imposed a national moratorium on writing new business for medical malpractice insurance for all physicians. Although St. Paul indicates this moratorium is only temporary, that remains to be seen.

Until recently, Virginia had three malpractice carriers. The Virginia Reciprocal Company announced in the fall of 1985 that it would no longer accept applications from obstetrician/gynecologists. The second carrier, St. Paul, as previously discussed, placed a moratorium on writing new business. The third, PHICO, will only insure obstetrician/gynecologists in groups of five or more. Seventy percent of obstetrician/gynecologists practice alone or in groups of less than five, yet an obstetrician/gynecologist who wants to open such a practice in Virginia today is unable to obtain insurance.

Another example of a crisis is West Virginia where virtually all physicians and hospitals across the state recently received cancellation notices from their carriers. By the end of May unless the courts or legislature intervene, the state will be virtually without malpractice coverage.

In 1985 both the American College of Nurse-Midwives and the ACOG had their nationally sponsored policies cancelled. Neither group has been able to locate a new source of group coverage and the American College of Nurse-Midwives has been forced to investigate the possibility of forming its own company. Unless this company can be operational by the end of the summer, nurse-midwives will also be virtually without insurance.

FREQUENCY OF SUITS

The problem is more than escalating premiums and the decreased availability of insurance. Physicians must consider the threat of a lawsuit with each patient they treat, and this damages the patient/physician relationship. Between 1979 and 1984, St. Paul reports that claims against physicians overall increased 107%. The typical obstetrician/gynecologist starting a 35 year career at the present time can expect to be sued eight times. Before 1976, one out of twenty obstetrician/gynecologists was sued each year. In 1986, one out of six will be sued.

Seventy-three percent of the Fellows surveyed by the ACOG in 1985 had had at least one professional liability claim filed against them. An increasing number are being sued more than once. For example, in 1985, 30% of Fellows had been sued three or more times. In New York and the Mid-Atlantic states (Pennsylvania, New Jersey and Delaware) 48% of ACOG Fellows have been sued three or more times. If medical care was getting worse, the crisis in liability would not be surprising, but all indications show better outcomes. Infant mortality rates are down, maternal mortality rates are down, yet the number of lawsuits is up.

As the frequency of lawsuits has increased, so has the cost. There were 70 awards of a million dollars or more in the area of medical malpractice in 1983, compared with 4 in 1976. It is becoming commonplace for juries to award verdicts in excess of a million dollars in medical malpractice cases.

ACCESS TO OBSTETRICAL CARE

In 1983, ACOG surveyed its members and found that nationwide 9% of our Fellows had quit the practice of obstetrics due to the risk of malpractice; in 1985 that figure had risen to 12.3%, an increase of more than 35% from 1983 to 1985. In Florida, one out of four obstetrician/gynecologists reported discontinuing obstetrics, about twice the national average. This figure was confirmed by a 1985 Florida Medical Association survey.

In many areas, one factor in the decision to discontinue obstetrics is that the premium for gynecology alone is substantially reduced. The current rate for physicians practicing only gynecology in Broward and Dade Counties in Florida is $51,800. Those who also practice obstetrics pay $118,000 or 127% more. Obstetricians pay 66% more in Montana and Utah, 96% more in Idaho, 97% more in Hawaii, and 111% more in Maryland, than their counterparts who practice only gynecology.

The 1985 ACOG survey took a closer look at those Fellows who have discontinued obstetrics due to the risk of professional liability. The age at which these physicians have discontinued obstetrics is disturbing: 25% quit before the age of 45 and 50% by the age of 55. Traditonally, obstetrician/gynecologists phase out their obstetrical practices as their patient population ages and make a normal transition to a gynecology-only practice around the age of 55. With so many of our Fellows discontinuing obstetrics before that age for liability reasons, it is clear that we are losing some of our most experienced and competent practitioners.

Although it is unlikely there will ever be a shortage of physicians willing to practice obstetrics in urban areas such as Washington, D.C. or New York City, the same is not true for rural areas. Pregnant women in rural areas in Nevada, the island of Molokai or in Kohalo, Hawaii are already experiencing physician shortages. These women are forced to travel to metropolitan areas for prenatal care and delivery. Many of them may not be able to afford, in terms of money or time, the necessary travel and will go without care. As health care providers in West Virginia may soon be without malpractice insurance, West Virginians may be forced to travel outside the state for health care.

ACOG EFFORTS

Three years ago, in attempt to better understand the problem, the College became the first medical specialty society to establish a department of professional liability. That department, which employs a full time staff of six, serves as a resource to Fellows of the College and to the public on professional liability issues, providing up-to-date information on professional liability insurance and educational materials on the legal system and risk management. As mentioned earlier, in 1983 and again 1985 the College conducted surveys of the membership to determine the effect of professional liability on the provision of obstetrical care. Our 1985 survey is appended. The department also works with other organizations, both medical and non-medical, to develop programs to alleviate the liability crisis. We have worked with attorneys and insurance carriers to better understand the dynamics between the quality of medical care rendered, the frequency of lawsuits, the size of awards or settlements, and the rate of insurance premiums.

Some attribute the liability problem to lawyers, or insurance carriers, or bad doctors, or to the public's expectation of perfection. We have learned that this is a multifaceted problem and no one group is solely to blame. The solution also lies in efforts by everyone. For example, it is difficult to allege avarice on the part of insurance companies when more than 50% of physicians are insured by physician-owned companies whose premiums continue to escalate at the same rate as commercial carriers. Nor can it be assumed that the problem has arisen solely from contentious attorneys. However, both the insurance industry and the legal profession must accept its responsibility to be part of the solution. With the amount of publicity given to "medical miracles," one can understand the public expectations of perfection. But perfection is an unrealistic goal in medical practice. Less than perfect outcomes occur even when no neglience exists. The tort system was not intended to compensate for injuries absent negligence, yet more and more damages are being awarded when the presence of negligence is questionable at best.

The "bad doctor" is also blamed by some for the current crisis. The fact that 73% of our Fellows surveyed have been sued indicates to us that virtually no one is immune from the threat of a lawsuit, no matter how well qualified or conscientious. While the facts do not demonstrate that the incompetent or impaired physician is to blame for the current crisis, the College believes advantage should be taken of the recent publicity to strengthen the processes for removing these physicians from the practice of medicine. State licensing boards alone have the authority to remove physicians from patient care and must be given adequate resources to do so. With legislative help, hospitals and the medical profession can improve their attempts to deal with the marginal practitioner. Physicians need assurance that information provided to appropriate authorities will be kept confidential and not result in litigation. Help is needed to protect hospitals and physicians from antitrust problems when peer review activities are undertaken in good faith.

The practice of medicine is constantly changing and the College serves as a major source of information to Fellows on the delivery of the most appropriate medical care. The ACOG publishes standards and guidelines for care, technical bulletins on specific subjects and procedures, and offers a quality assurance program for use by hospitals. We provide a number of scientific meetings, 25-30 post-graduate courses, nine regional meetings and a national clinical meeting each year. A variety of printed and taped educational tools are also available.

FEDERAL ROLE

Despite some success through state enactment of reforms, not all states' efforts have been effective and most still have serious liability problems. A national liability crisis is a reality.

West Virginia provides an excellent example of the limitations of state action. On March 8, 1986, the West Virginia legislature adopted a comprehensive measure to address the liability insurance problem in that state. Although the law has not yet taken effect, the three major carriers for medical malpractice insurance announced they are cancelling all policies in West Virginia rather than comply with provisions of the new law. The Attorney General of West Virginia has filed suit and a special session of the state legislature has been called to address the issue. But in the meantime, physicians must decide whether to discontinue practice, relocate to another state or practice without insurance. And patients wonder if any medical care will be available to them.

The individual states can no longer deal with this problem. In the field of medicine, doctors are increasingly held to national standards of care. It is time for national leadership to assert its role and address the tremendous liability problems facing this country. The ACOG looks to the Congress to develop model solutions aimed at solving the recurrent liability insurance crisis and the resulting threat to continued access to high-quality maternity care for the women of this country.

The federal government through Medicare, Medicaid, Champus and other programs provides health care for many citizens. The liability crisis affects the cost and access to such health care. Given the fact that the federal government pays nearly 40% of the nation's health care expenditures, it is inappropriate for the Congress to ignore a major problem affecting costs and access to this care.

Senator Hatch is to be commended for introducing a bill to address this problem. This bill, S. 1804, encourages the states to adopt tort reforms, to require risk management programs by insurance companies and to improve the functioning of state disciplinary boards. All of these, if adopted in the fifty states, would positively impact on the liability problem.

While the ACOG supports such efforts we are convinced the problem will not be fully resolved until alternative dispute resolution systems are available. The current system for compensating injured parties is time consuming, frequently resulting in delays of 2-5 years in receiving payment. It is also inefficient, with as little as 28% of the premium dollar being received by the injured parties. We contend that a system which returns so little of the premium dollar to the injured party and which requires so much time for the settlement of disputes is unacceptable.

The ACOG has endorsed S. 1960, a bill pending before the Finance Committee which was introduced by Senators Durenberger and Danforth. This bill provides a comprehensive approach to professional liability and holds promise to provide prompt payment to injured parties with a significant reduction in the costs associated with settling claims. By eliminating the necessity for physicians and patients to be adversaries, it will reduce the tension between them. We believe such an approach would lead to greater predictability for insurance carriers and reduce pressures for the escalation of premiums to cover unpredictable losses.

The prompt payment mechanism of S. 1960 defines the recoverable amount according to rules similar to the tort reforms included in S. 1804. Awards would be reduced by amounts received from other sources and future damages would be paid in periodic payments. No payments would be made for noneconomic damages.

We recognize that this approach is a novel idea which has not yet been tried in the United States. However, if the recurrent liability problem is to be addressed in a meaningful way the tort system itself must be examined. The College urges this Committee to carefully consider this and other alternative dispute resolution mechanisms.

STATE ACTIVITIES

For years, federal legislators have responded to problems in professional liability by saying that the crisis must be addressed in areas traditionally left to the states -- establishing rules for tort actions and regulation of insurance. The states have been active in these areas. Most states have enacted changes in their tort laws over the past decade. Some have tried a number of more creative mechanisms, such as patient compensation funds, joint underwriting associations, and mediation panels.

One element of tort reform that may be more important to obstetricians than other physicians is shortening the statute of limitations for minors. In some states the period in which a suit can be brought extends beyond the age of majority. Thus for an alleged injury at birth, actions can be brought after more than twenty years. Such cases are obviously difficult to defend. Even good memories fade after twenty years, the whereabouts of all relevant parties may not be known and standards of practice may have changed dramatically.

A cap on noneconomic losses, such as pain and suffering, has been an element in effective tort reform. This type of cap does not limit in any way recovery for economic losses, such as medical care or lost income. However, it does limit what could otherwise be unlimited recoveries since noneconomic losses are difficult to quantify, as well as to insure. This type of legislation is a reasonable approach since the plaintiff still receives full compensation for economic losses.

Another effective reform is the mandatory offset against tort awards for compensation received from other sources, sometimes referred to as elimination of the collateral source rule. The current system allows plaintiffs double recoveries since they can recover from government or private insurance companies and also in tort. To the extent that injuries are compensated more than once, insurance costs for all are increased.

Periodic payments provide another way to reduce the costs of liability actions without preventing the plaintiff from receiving a fair recovery. If the tort award for future damages is paid out over time rather than all at once, both the plaintiff and defendant benefit. The plaintiff is assured that money will be there when it is needed and the defendant's payout is made more predictable.

This is certainly not an exhaustive list of tort reforms which if adopted across the country could impact on the liability crisis. Other reforms which should be considered beneficial include elimination of joint and several liability, limits on attorneys' contingency fees, penalties for non-meritorious suits, screening panels, binding arbitration and elimination or limits on punitive damages.

CONCLUSION

Mr. Chairman, we appreciate your efforts to examine this problem and the leadership the Committee has shown in recognizing that the liability problems facing this country are national in scope, transcending state boundaries. The College urges the Committee to give serious consideration to alternative dispute resolution systems when addressing this problem. We look forward to working with you in the future, and I would be delighted to answer any questions you may have.

PROFESSIONAL LIABILITY INSURANCE AND ITS EFFECT: REPORT OF A SURVEY OF ACOG'S MEMBERSHIP

November 1985

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1. INTRODUCTION

A major concern of the American College of Obstetricians and Gynecologists (ACOG), as well as healthcare administrators and professionals involved in prenatal care and delivery, is the significant and increasing cost of medical liability insurance. Liability insurance for OB/GYNs ranks among the highest for any medical speciality and is known to be as much as $72,000 annually in some areas of the country (e.g., Long Island). ACOG is not only concerned with the impact of such insurance rates on their membership in terms of financial pressure, medical procedures and professional prestige, but also with the effect on patient medical costs and availability of care.

To examine the effects of the cost of liability insurance as well as the increased risk of being sued for malpractice, a cross-sectional mail survey was conducted of a stratified random sample of ACOG's membership in the summer of 1985. The survey formed the second stage of a two stage research effort designed to obtain valid, reliable information regarding these issues. The methodology involved in this effort is described in the following section.

2. METHODOLOGY

2.1 Questionnaire Construction

The first stage of the research effort consisted of 15 in-depth interviews with practicing OB/GYNs who had experience with a malpractice claim. These preliminary interviews were designed to identify the major issues related to professional liability and thus provide a firm foundation for developing the quantitative study. Physicians were interviewed in person in the Washington, D.C. area and by telephone in other regions of the country.

Some of the issues addressed in the in-depth interviews included the following:

- Basis for the origin of malpractice claims;
- Process involved in resolving claims; and
- Effect of malpractice claim on physician's practice.

The interview results were then analyzed and a draft questionnaire was developed with the cooperation of ACOG's Department of Professional Liability. The draft questionnaire was pre-tested among a small sample of ACOG Fellows throughout the country and minor modifications were made as necessary to increase the clarity and comprehensiveness of the instrument. The final questionnaire is presented in the Appendix.

2.2 Sampling

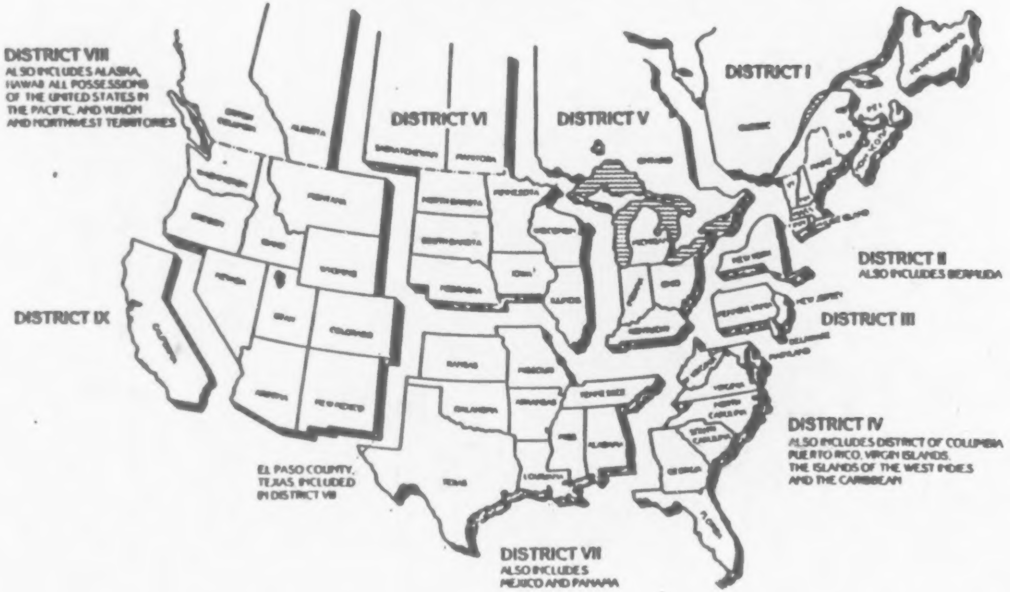
The sampling plan was designed to ensure that nine of ACOG's districts (excluding District X (see Chart 1)) as well as the state of Florida were adequately represented so as to allow separate examination of their responses. Since Districts II and IX represent the states of New York and California, respectively, the plan thus permitted the detailed analysis of three important states: New York, California and Florida. A random sample was drawn from ACOG membership records.

Chart 1

THE NINE GEOGRAPHICAL DISTRICTS OF

The American College of Obstetricians and Gynecologists

Armed Forces District includes all Fellows on active duty in the Military Services or who, upon retirement, maintain membership in this District.


DISTRICT VIII
ALSO INCLUDES ALASKA, HAWAII ALL POSSESSIONS OF THE UNITED STATES IN THE PACIFIC, AND YUKON AND NORTHWEST TERRITORIES
DISTRICT IX
DISTRICT VI
DISTRICT V
DISTRICT I
DISTRICT II
ALSO INCLUDES BERMUDA
DISTRICT III
NEW JERSEY
DELAWARE
MARYLAND
DISTRICT IV
ALSO INCLUDES DISTRICT OF COLUMBIA PUERTO RICO, VIRGIN ISLANDS, THE ISLANDS OF THE WEST INDIES AND THE CARIBBEAN
DISTRICT VII
ALSO INCLUDES MEXICO AND PANAMA
EL PASO COUNTY, TEXAS INCLUDED IN DISTRICT VIII

Four strata with variable sampling rates were created to assure that sample sizes would be sufficiently large for statistically reliable results in each ACOG district individually and in Florida. This required that areas with smaller populations be oversampled in the following manner within the four strata:

Region	Sampling Ratio
Florida	1 in 2
District I	1 in 3
District II (New York) District VI District VIII	1 in 4
Districts III, V, VII, IX District IV excluding Florida	1 in 5

This design yielded a sample of 4,143 physicians.

As mentioned, District X (composed of OB/GYNs in the military) was deleted from the sampling frame in order to match the sampling procedure of ACOG's 1983 study.* In addition, three other groups were deleted from the sampling frame: members outside of the 50 states, Junior Fellows still in residency, and inactive members. Junior Fellows in residence were eliminated as a function of their "term date" -- all those with a term date of 1988 or beyond were deleted. Additional inactive practitioners (a total of 11.3% of the respondents) were deleted post hoc as a function of their self-identification in the survey responses.

Chart 2 gives the actual sample size and the response rate by region.

---

* "Professional Liability Insurance and Its Effects: Report of a Survey of ACOG's Membership," August 31, 1983.

Chart 2

OVERALL NUMBER OF ACTUAL* RESPONDENTS AND RESPONSE RATES, BY GEOGRAPHIC DISTRICT

(unweighted)

		N	Response Rates
TOTAL		1,646**	39.7
I.	New England	125	35.3
II.	New York	151	36.7
III.	Mid Atlantic	118	35.4
IV.	Southeast Excluding Florida	215	43.2
V.	Great Lakes	152	42.2
VI.	Middle North	164	40.7
VII.	Middle South	201	37.3
VIII.	West	176	47.7
IX.	California	168	38.0
	Florida	173	39.9

---

* Response rate totals include the following ineligible respondents:

- o Junior Fellows still in residence;
- o retired individuals;
- o teaching only individuals; and
- o individuals indicating "other" as their Type of Practice.

** Totals for geographic regions omit individuals who did not indicate in what state their practice is located.

2.2.1 Expected Sampling Error and Statistical Significance. The reason for pursuing the sampling and field procedures outlined in the previous sections was to produce an unbiased sample of the study population which would have the same properties and characteristics of the population from which it was drawn--subject, of course, to a certain level of sampling error, and subject to deliberately imposed restrictions on the population such as the desire in this case to be overly representative of Fellows as opposed to Junior Fellows. We can derive the maximum expected sampling error for a simple random probability sample from the following formula:

$$S\ (x) = z_{\alpha/2} \sqrt{\frac{p(q)}{n-1}} \qquad \text{where:}$$

$S\ (x)$ = the expected sampling error of the mean of some variable, expressed as a proportion;

z = the standard normal score for some confidence limit;

p = some proportion of the sample displaying a certain characteristic or giving a certain answer on some variable or question;

q = $1.0 - p$; and

n = the size of the sample.

Assuming a desired confidence level of 95%, for example, the formula can be solved for the maximum expected sampling error for various sample sizes or sample splits (e.g., geographic district).

We need only to perform some simple calculations in order to test whether or not a difference between two subsample proportions is statistically significant. We can obtain the sampling error of the difference between two selected samples by figuring:

$$S_d = \sqrt{S^2{}_1 + S^2{}_2} \qquad \text{where:}$$

S_1 = the total sampling error of the first subsample;
S_2 = the total sampling error of the second subsample; and
S_d = the sampling error of the difference.

Any difference between observed proportions that exceeds S_d represents a significant difference.

The sampling error for response distributions of groups of different sizes is given in Chart 3, expressed as percentages. With a limited amount of interpolation and calculation, the statistical significance of differences observed in the majority of the following tables can be established fairly easily. Chart 4 presents the sample sizes used in the analyses upon which the estimates of statistical significance should be based. In viewing the tables presented, it is important to recognize that the percentages are based on numbers that have been weighted up to represent the survey population estimate rather than the actual sample response. It also should be noted that, since the estimates of pooled sampling error were calculated on a binomial distribution where $p = 0.5$, the values presented in Chart 3 should be viewed as indicating the maximum difference values required for giving statistically significant contrasts; this then provides the most conservative estimates of significance.

To ascertain whether the difference between any two proportions on a given table is significant, the following steps would be performed. For example, in order to examine the significance of the difference on Table 4: Predominant Type of Practice (examining regional differences in the fee for service, solo practice types), one would first calculate the difference between the desired regional responses (e.g., 55.1% (New York) - 31.4% (Mid North) = 23.7%). Next, find the actual sample size for both regions by referring to Chart 4 (e.g., 133 (New York) and 148 (Mid North)). Finally, using the actual sample sizes, refer to Chart 3 to determine how large a difference must be in order to reach statistical significance (e.g., given an initial sample size of approximately 150 and a second sample of approximately 150, a difference must exceed 11.4 percent in order to reach significance).

Chart 5 gives the expected sampling error for different percentage distributions within a single sample at a 95 percent confidence level. Thus, with a sample of 1,500 and a distribution where 90 percent of the respondents fall in one category (10% in the other category), the estimate provided by the sample is accurate within plus or minus 1.5 percent. With a more heterogeneous distribution (50-50) the estimate is expected to be accurate within plus or minus 2.5 percent.

Chart 3

PERCENTAGES WHICH INDICATE A STATISTICALLY SIGNIFICANT DIFFERENCE BETWEEN TWO SUBSAMPLES

(Assuming p=q, at 95% Confidence Level)

Size of Sample 2	Size of Sample 1 100	150	200	250	300	400	1200
100	13.9	12.7	12.1	11.6	11.4	11.0	10.2
150		11.4	10.6	10.2	9.8	9.4	8.5
200			9.8	9.3	9.0	8.5	7.5
250				8.8	8.4	7.9	6.8
300					8.0	7.4	6.3
400						6.9	5.7
1200							4.0

Chart 4

UNWEIGHTED SAMPLE SIZES FOR RELEVANT COMPARISONS
(Excluding ineligible respondents)

	Region	Actual Sample Size*
I.	New England	111
II.	New York	133
III.	Mid Atlantic	105
IV.	Southeast Excluding Florida	196
V.	Great Lakes	138
VI.	Middle North	148
VII.	Middle South	183
VIII.	West	156
IX.	California	151
	Florida	137

*These totals omit individuals who did not indicate in what state their practice is located.

Chart 5

Expected Sampling Error (Plus or Minus) at 95% Confidence Level (Simple Random Sample)

Percentage of the sample or subsample giving a certain response or displaying a certain characteristic for percentages near:

Size of Sample or Subsample	10 or 90	20 or 80	30 or 70	40 or 60	50
2500	1.2	1.6	1.8	1.9	2.0
2400	1.2	1.6	1.8	2.0	2.0
2300	1.2	1.6	1.8	2.0	2.0
2200	1.3	1.7	1.9	2.0	2.1
2100	1.3	1.7	2.0	2.1	2.1
2000	1.3	1.8	2.1	2.2	2.2
1900	1.3	1.8	2.1	2.2	2.2
1800	1.4	1.8	2.1	2.3	2.3
1700	1.4	1.9	2.2	2.3	2.4
1600	1.5	2.0	2.2	2.4	2.5
1500	1.5	2.0	2.3	2.5	2.5
1400	1.6	2.1	2.4	2.6	2.6
1300	1.6	2.2	2.5	2.7	2.7
1200	1.7	2.3	2.6	2.8	2.8
1100	1.8	2.4	2.7	2.9	3.0
1000	1.9	2.5	2.8	3.0	3.1
900	2.0	2.6	3.0	3.2	3.3
800	2.1	2.8	3.2	3.4	3.5
700	2.2	3.0	3.4	3.6	3.7
600	2.4	3.2	3.7	3.9	4.0
500	2.6	3.5	4.0	4.3	4.4
400	2.9	3.9	4.5	4.8	4.9
300	3.4	4.5	5.2	5.6	5.7
200	4.2	5.6	6.4	6.8	6.9
100	5.9	7.9	9.0	9.7	9.8
75	6.8	9.1	10.4	11.2	11.4
50	8.4	11.2	12.8	13.7	14.0

Note: Entries are expressed as percentage points (+ or -).

3. RESULTS

3.1 Physicians' Demographics

Tables 1 through 3 present respondents' demographic characteristics, including the following:

- -- Sex
- -- Age
- -- Number of years in practice

Sex and Age (Tables 1-2)

- o The majority of respondents were male (93.0%). Geographically, females were relatively more highly represented in the New York region (12.8%) and were under represented in the West region (3.2%).

- o Nearly 90 percent of all respondents were between 35 and 65 years of age. Respondent ages were evenly distributed among each of the middle age ranges; with 34.1 percent ages 35 through 44; 31.3 percent ages 45 through 54; and 24.3 percent ages 55 through 64 years old. Small proportions of younger (2.5% less than 35 years) and older (7.9% 65 years and older) physicians responded.

- o The average age of respondents was 49.6 years. A few differences in ages were apparent across regions. OB/GYNs in New England and New York regions were more likely to be 55-64 years of age (29.7% and 33.1%, respectively vs. 24.3% overall). Physicians surveyed in the Mid South and West were more likely to be 35-44 years old (38.5% and 44.2%, respectively vs. 34.1% overall). In Florida, OB/GYNs were more likely to be between 45-54 years old (41.6% vs. 31.3% overall).

Years Practicing (Table 3)

- Of all those OB/GYNs surveyed, 32.3 percent had been in practice 11-20 years, 24.8 percent had been in practice 21-30 years, and 23.2 percent had been practicing 6-10 years. Few OB/GYNs had been in practice for more than 30 years (12.5%) or for five or fewer years (7.2%).

- Across all respondents, the mean number of years spent in practice was 18.1. Responses across regions indicated differences in the number of years they had been in practice. Consistent with the regional difference in age distribution, physicians in the New England and New York regions were more likely to have been in practice 21-30 years (30.6% and 32.3%, respectively vs. 24.8% overall). In addition, OB/GYNs in the Mid Atlantic region were also more likely to have been in practice 21-30 years (30.5%). Also consistent with the age distribution, doctors in the Mid South and West were more likely to have been in practice 6-10 years (29.1% and 29.5%, respectively vs. 23.2% overall).

3.2 Practice Description

Tables 4 through 10 present an analysis of the survey questions describing OB/GYN practices. Topics discussed in this section include the following:

- Predominant type of practice
- Gross income from medical practice
- Percent practicing obstetrics
- Physicians not practicing obstetrics
- Number of deliveries per month
- Percent of obstetrical practice devoted to high-risk care

Predominant Type of Practice (Table 4)

- A total of 92.0 percent of all respondents reported being in a fee for service practice. Of these, 45.2 percent were in solo practice, 40.2 percent were in a single specialty partnership or group practice, and 6.6 percent were in a multispecialty group or partnership.

- Regional variations were apparent. Compared to a 45.2 percent overall rate of solo practices, New York (55.1%) and California (55.2%) were high, while the Mid North (31.4%) was low. The South East region was more likely to have single specialty groups and the California region was less likely (50.0% and 30.3%, respectively vs. 40.2% overall). The Mid North region had a relatively high percentage of multi-specialty groups represented (23.3% vs. 6.6% overall).

Gross Income from Medical Practice (Table 5)

- Of all OB/GYNs surveyed, the mean gross income from their medical practice in 1984 was $215,011. Overall, 34.2 percent of respondents reported gross incomes of $250,000 or more, 30.6 percent had gross incomes between $150,000 and $249,999, 21.4 percent indicated gross incomes between $100,000 and $149,999, and 13.8 percent reported gross incomes below $100,000.

- Regional analyses revealed that a higher percentage of physicians in the Mid South (44.0%), California (46.1%) and Florida (44.4%) had gross incomes of $250,000 or more (compared with 34.2% overall) while physicians in the South East (23.3%) were least likely to be in this category.

Percentage of Practice Devoted to Obstetrics (Table 6)

- The majority of respondents (68.3%) devote 50 percent or less of their practice to obstetrics. Overall, 45.1 percent of OB/GYNs reported that 26-50 percent of their practice was devoted to obstetrics, 26.8 percent devote 51-75 percent to obstetrics; 23.2 percent devote 25 or less percent of their practice to obstetrics. Only 4.8 percent said they practiced obstetrics more than 75 percent of their time.

- OB/GYNs in the South East region were more likely to devote between 26 and 50 percent of their practice to obstetrics (50.3%), while physicians in the Mid South and Florida were less likely to be in this category (38.0% and 37.8%, respectively vs. 45.1% overall). Physicians in New York (36.5% vs. 26.8% overall) were more likely to devote 51 to 75 percent of their practice to obstetrics, while OB/GYNs in the South East (18.6%) were less likely to do so.

Physicians Not Practicing Obstetrics (Tables 7-8)

- Of those physicians not practicing obstetrics, 6.8 percent of respondents reported never having practiced obstetrics. Physicians in the New York region (18.2%) were most likely to report never having practiced obstetrics. However, the majority of respondents who do not currently practice obstetrics (93.2%) reported stopping at some point during their career.

- More than half of the physicians who stopped practicing obstetrics did so before the age of 54. Few physicians (2.8%) stopped practicing obstetrics before age 35 and 84.9 percent stopped their obstetrical practice before reaching age 65.

- Regional differences were observed in the age at which physicians stopped practicing obstetrics. Compared with the overall mean of 22.5 percent physicians in New England, Florida and the Mid South were more likely to stop between ages 35 and 44 (42.9%, 40.9%, and 33.3%, respectively). Respondents from the South East, Mid North and Mid South regions were more likely to stop between ages 45 and 54 (47.6%, 40.0%, 38.1%, respectively vs. 28.9%), while physicians in the Great Lakes and California regions were more likely to stop obstetrics between the ages of 55 and 64 (50.0% and 44.4% compared with 30.7%, overall). Of the 15.1 percent overall who stopped obstetrics after the age of 65, respondents in New York and California were more likely to stop at this age (33.3% and 27.8%, respectively).

- Other regional differences showed that physicians in several regions were less likely than the average to stop obstetrics at particular ages. OB/GYNs in the Great Lakes (7.1%), Mid North (10.0%) and California (11.1%) were less likely to stop between ages 35 and 44. New York physicians (11.1%) were less likely to stop between ages 45 and 54, while those in New England (7.1%) were less likely to stop obstetrics between the ages of 55 and 64. Additionally, few respondents in the Mid South (4.8%) reported stopping after the age of 65.

Average Number of Deliveries Performed Per Month (Table 9)

- Of those who performed deliveries, respondents varied considerably in the average number of obstetrical deliveries that they perform. While over one third (36.5%) of all respondents delivered an average of between 8-12 babies per month, 25.2 percent delivered 13-19 babies a month, 20.8 percent delivered 1-7 babies per month and 17.5 percent reported delivering 20 or more babies per month.

- Physicians in New York and the South East delivered fewer babies than any other regions with 34.5 percent and 28.5 percent, respectively, delivering 1-7 babies. Respondents in the Mid Atlantic and Great Lakes regions were more likely to perform 13-19 deliveries per month (30.2% and 31.6%, respectively). Respondents in the Mid South and West were more likely to perform the highest numbers (20 or more) of deliveries per month (24.8% and 24.6%, respectively).

Percentage of Obstetrical Practice Devoted to High Risk Care (Table 10)

- Of all physicians who practice obstetrics, 50.1 percent devote 11-20 percent of their obstetrics practice to high-risk care. One quarter of these physicians devote 21-30 percent of their obstetrical practice to high-risk care while nearly another quarter (23.2%) devote 30 percent or more of their obstetrical practice to high-risk care.

- Regional variations revealed that respondents in the Mid Atlantic (60.5%) region were most likely to spend between 11 and 20 percent of their time on high-risk obstetrical care. Physicians in New England (35.6%) were relatively more likely to spend between 21 and 30 percent of their time in this high-risk area.

3.3 Professional Liability Insurance

Tables 11 through 16 present OB/GYNs responses to questions concerning their primary coverage and expenses of professional liability insurance. Professional liability insurance is discussed in reference to:

- Coverage by professional liability insurance
- Cost of primary insurance coverage in 1984
- Comparison of the 1984 annual costs of primary coverage to those reported in the 1983 survey
- Reported annual premium increase since 1983 and comparison with the 1983 survey responses for the previous two year increase
- Cost of primary coverage relative to gross income

Coverage by Professional Liability Insurance (Tables 11-12)

- Of all OB/GYNs surveyed, 98.1 percent reported being covered by professional liability insurance. This response was consistent across regions with one exception. Physicians from Florida were more likely (8.0%) to be without professional liability insurance.

- Of all respondents who are covered by professional liability insurance, over half (52.4%) have primary coverage per claim of between $500,001 and $1,000,000. Nearly one quarter of OB/GYNs (23.2%) had primary coverage under $250,000. One-tenth of those surveyed had primary coverage per claim ranging from $250,001 to $500,000 (10.1%) while another 10.9 percent were covered from $1,000,001 to $3,000,000. Only 3.4 percent of respondents had coverage exceeding $3,000,000 per claim.

- Respondents from different regions varied in their limits of primary coverage per claim. Physicians in the Great Lakes and Mid Atlantic regions were more likely than the average (23.2%) to report having the lowest level of primary coverage 72.3 percent and 47.8 percent, respectively, while very few physicians in New York (2.5%), New England (5.2%), California (5.8%) and the West (8.2%) reported under $250,000 in primary coverage per claim. More respondents in Florida (31.6%) than in any other region (10.1% overall) reported primary coverage in the $250,001 - $500,000 range. Physicians from

New York (90.0% vs. 52.4% overall) were most likely to have primary coverage per claim of $500,001 - $1,000,000. OB/GYNs in the West (36.6%) and South East (27.6%) were most likely to have primary coverage greater than $1,000,000 per claim.

Cost of Primary Insurance Coverage in 1984 (Tables 13)

- The expenses of OB/GYNs liability insurance in 1984 varied. Overall, respondents paid an average of $20,818 for primary insurance coverage, with 59.1 percent of all OB/GYNs paying between $8,000 - $24,999.

- There were variations across regions in the costs of primary coverage in 1984. Respondents in the Great Lakes and Mid South regions were more likely to pay less than $15,000 (74.8% and 76.8%, respectively vs. 42.3% overall). Mid Atlantic physicians were most likely to have primary insurance expenses between $15,000 and $24,999 (66.7% vs. 30.6% overall).

  More respondents in New York (77.6% vs. 27.1% overall) and Florida (68.0%) paid over $25,000 for their primary coverage.

Comparison of 1984 Annual Costs of Primary Coverage to Those Reported in the 1983 Survey

- The annual cost of primary coverage in 1984, reported in the present study, was compared to the annual cost of coverage reported in the 1983 survey. This comparison revealed a substantial rise in the annual cost of primary coverage. While 66.3 percent of the 1983 physicians reported primary insurance expenses under $15,000, only 42.3 percent of 1985 respondents indicated expenses under $15,000. In 1983, 9.4 percent of all respondents paid more than $25,000, while in 1985, 27.1 percent of the respondents had annual primary coverage expenses at this level. Across all regions, the proportion of physicians paying more than $25,000 for their primary insurance coverage increased from the 1983 survey to the current study, with the most dramatic increases seen in Florida (12.6% vs. 68.0%), New York (36.7% vs. 77.6%), California (21.8% vs. 48.5%), the West (2.8% vs. 24.8%), and the Mid North (12.2% vs. 33.6%).

Reported Annual Premium Increases Since 1983 (Tables 14-15)

- When directly asked, 92.8 percent of all respondents in the 1985 survey replied that their annual premium has increased since 1983. In contrast, 61.9 percent of physicians queried in 1983 reported having their annual premiums increased during the previous two years. In the 1983 survey, Florida (84.6%) and New York (81.9%) had greater proportions of respondents reporting an increase while those in the Great Lakes (45.8%) and Mid South (44.9%) were least likely to report an increase. In 1985, respondents in the Mid North (98.6%) were most likely to report an increase, while OB/GYNs in California (85.0%) and the Mid South (85.8%) were least likely to do so. However, the percentages reporting increases in California and the Mid South were higher than those in Florida and New York in 1983.

- Overall, respondents to the 1985 study reporting increases said that premiums had risen an average of $9,871 since 1983. OB/GYNs responding to the 1983 survey indicated this mean increase to be $4,607 over the previous two years.

- The increases in premiums reported by 1985 respondents were as follows: 31.4 percent reported increases of $4,000 - $7,999, 23.4 percent said their premiums rose $8,000 - $12,999, 23.9 percent indicated increases of $13,000 or more, and 21.4 percent reported increases less than $4,000.

- Regional analysis of the 1985 study shows that New York, Florida and the Mid North had the highest increases in annual premiums where increases occurred. New York OB/GYNs premiums rose an average of $21,635, Florida's premiums increased an average of $17,131, while premiums in the Mid North rose an average of $13,361. Premiums in the Mid South rose least with an average of $5,199. In comparison, the 1983 data also showed the highest mean increases to be in New York ($8,538) and Florida ($8,115).

- Of those reporting increases, respondents in the Great Lakes (40.7%) and Mid South (38.6%) regions were more likely to report smaller increases (less than $4,000). In contrast, physicians in New York (66.7%), Florida (52.3%) and the Mid North (43.6%) were more likely to report increases of $13,000 or more.

Cost of Primary Coverage Relative to Gross Income (Table 16)

- Mean values for the cost of primary coverage for respondents who are covered by liability insurance were divided by the mean values of gross income for respondents in each region. This calculated percentage, the expense of primary coverage as a percent of gross income, was 9.7 percent overall. While this percentage was generally consistent across most regions, New York (16.3%) and Florida (12.1%) had the highest percentages.

3.4 Professional Liability Claims Experience

Tables 17 through 30 discuss OB/GYNs responses to questions concerning their professional liability claims experiences. These experiences are reported in reference to the following:

- Number of professional liability claims filed against physicians
- Primary bases of malpractice claims
- Length of time between incident and filing of claim
- Experience with completed professional liability claims
- Status of insurance claim
- Length of time between filing and settling of the claim
- Amount paid on physician's behalf to settle claim
- Length of time between filing of claim and outcome of contested case
- Outcome of contested cases
- Malpractice suits increasing specific activities in practice
- Changes in practice as a result of malpractice
- Increases in professional fees resulting from increases in malpractice premiums

Number of Professional Liability Claims Filed Against Physicians (Table 17-18)

- Overall, 73.0 percent indicated that they had had at least one professional liability claim filed against them. A relatively higher percentage of physicians in the Mid Atlantic (86.7%), New England (82.7%) and New York (81.2%) regions indicated they had had at least one liability claim, while a relatively lower percentage of physicians in the South East (64.9%), California (65.6%), and the Mid South (67.0%) regions reported having at least one claim experience.

- Overall, 24.5 percent of respondents had had one claim, 19.5 percent had two claims and 28.5 percent had three or more claims filed against them. Regional variations revealed that physicians from New York (48.5%) and the Mid Atlantic (46.6%) regions were more likely to have had three or more claims filed against them.

- Comparison of these data with responses from ACOG's 1983 survey reveals a general rise in the number of claims filed against OB/GYNs, with 48.0 percent vs. 35.9 percent having faced two or more claims for 1985 and 1983, respectively.

Primary Bases of Malpractice Claims (Table 19)

- Of the primary allegations listed by physicians who had professional liability claims filed against them, gynecological patient injury was the basis for the largest single percentage (23.9%) of all malpractice claims filed. There was little regional variation in the percentages which fell into this category. Brain damage or injury to the infant accounted for 20.4 percent of the malpractice claims, with physicians in New York (30.2%) more likely to face this type of claim than any other region.

Length of Time between Incident and Filing of Claim (Table 20)

- One third of physicians (33.1%) reported a time lapse of one to three years between the incident in question and the filing of the claim, 19.1 percent indicated that between six and twelve months had passed and 10.4 percent indicated that less than six months had elapsed. Nearly as many, 9.2 percent, reported that more than three years between the incident and the filing of the claim elapsed.

- Compared to the overall (33.1%), Mid Atlantic (49.5%) and Florida (44.3%) OB/GYNs were more likely to report one to three years passing between the incident and filing of the claim. California's physicians (41.4%) were more likely than the 29.5 percent overall to have less than one year elapse between incident and filing.

Experience with Completed Professional Liability Claims (Table 21)

- Of all OB/GYNs who had claims filed against them, 71.1 percent reported having experience with completed claims. Respondents in California (83.3%) and the Mid Atlantic (82.0%) regions were particularly likely to report having completed such an experience. In contrast, New York physicians (57.7%) were least likely to have completed professional liability claims. Physicians who had experienced completed professional liability claims were asked to provide specific details related to the completed claim they considered most serious or significant. Tables 22 to 26 refer to this claim.

Status of Insurance Claim (Table 22)

- Of those respondents who had experienced completed liability claims, 71.4 percent settled the cases. The proportion of contested cases was highest in Florida (38.2%), the South East (37.9%) and Mid South (33.7%), compared with 28.6 percent contested overall.

Length of Time Between Filing and Settling of the Claim (Table 23)

- The majority of claims (69.3%) took at least one year to settle. Claims in New York took longer to settle than in other regions.

Amount Paid on Physician's Behalf to Settle Claim (Table 24)

- Among physicians who settled the claim, the median sum paid to settle claims was $30,000 while the mean amount was $178,567. Overall, 12.9 percent paid less than $5,000, while half the respondents who settled a claim (51.3%) settled for between $5,000 and $99,999. One fifth (20.0%) had $100,000 to $999,999, and only 4.6 percent had over $1,000,000 paid on their behalf. The remaining 11.1 percent paid nothing in order to settle the claim.

- Physicians in New England (37.5%) and Florida (29.3%) were more likely to settle the claim for higher amounts ($100,000 to $999,999) while those in the South East (18.4%) were most likely to settle without payment.

Length of Time Between Filing of Claim and Outcome of Contested Case (Table 25)

- For those respondents whose liability cases were contested, 44.4 percent overall said that two to five years elapsed between the time the claim was filed and the outcome was reached, while another 25.6 percent said that the elasped time was between one and two years. The length of time between filing and outcome of contested cases was longest in the New York and California regions (84.6% and 84.2% of respondents, respectively, indicated that it took more than two years). In contrast, respondents in the South East and New England regions were most likely to indicate a shorter length of time between filing and outcome. In both regions, 33.3 percent of the respondents said the duration between contested claim filing and outcome was less than one year, compared to 19.3 percent of respondents overall.

Outcome of Contested Cases (Table 26)

- Of those respondents whose cases were contested in court, 80.9 percent reported that they won the case. These percentages were lower in New York (61.5%) and the Mid Atlantic region (71.4%)

- The dollar amount paid on behalf of those respondents who lost contested cases is not reported in this study, because most respondents settle cases or win contested cases so that the respondent base for this category is too small to provide a sound statistical basis for meaningful conclusions about trends.

Malpractice Suits Increasing Specific Activities in Practice (Table 27)

- Overall, a high percentage of physicians reported having increased the frequency with which they performed a number of activities as a result of their liability claims experiences. About two-thirds said they more frequently explained potential risks of recommended procedures, documented other activities such as office visits and phone calls, and performed more testing and diagnostic procedures (64.4%, 68.2%, and 67.8%, respectively). Increases in the frequency of monitoring procedures (58.8%), the provision of taped or written information to patients (49.1%), consultations with other physicians (44.2%) and obtaining written informed consent (43.1%) were also reported.

- Although the extent of reported increases in these activities was generally consistent across regions, there was some regional variation. Compared to respondents overall, California physicians were more likely to report that they more frequently provided written or taped information to patients (59.0%), obtained written informed consent (61.5%), and explained potential risks of recommended procedures (74.4%). New York physicians were more likely than respondents overall to indicate that they have increased the number of referrals to other physicians (50.0%) along with testing and diagnostic procedures (77.6%). Physicians in the Mid North region were less likely than respondents overall to report an increase in physician referrals (25.7%) or an increase in obtaining written informed consent (31.1%).

Changes in Practice as a Result of Risk of Malpractice (Tables 28)

- Since the 1983 survey the percentage of respondents overall, who have made no changes in their personal practice as a result of the risk of malpractice has decreased from 68.2 percent to 62.9 percent. Comparing the 1983 and present survey, the overall percentage of respondents indicating decreases in their level of high risk obstetrical care increased from 17.7 percent to 23.1 percent. The percentage indicating decreases in the number of deliveries they perform increased from 10.1 percent to 13.7 percent, and the percentage indicating that they no longer practice obstetrics increased from 9.1 percent to 12.3 percent.

- Regional variations revealed the percentage reporting "no changes" dropped from 63.0 percent in 1983 to 55.9 percent in 1985 in New York, from 72.0 percent to 59.4 percent in the Mid Atlantic, from 77.3 percent to 65.9 percent in the South East, 69.3 percent to 53.5 percent in the Great Lakes, and from 52.7 percent to 44.1 percent in Florida. Contrary to this overall trend, the percentage of respondents indicating no practice changes increased in the New England region from 53.9 percent in 1983 to 71.8 percent in 1985.

- Physicians who indicated that they had done at least one of the following: decreased the number of deliveries, decreased the level of high risk obstetrics care or no longer practice obstetrics were combined together to determine the percentage of OB/GYNs who had made a significant change in their obstetrical practice. Compared with 35.0 percent overall, OB/GYNs in Florida (53.3%) and in the Great Lakes region (44.9%) reported making any changes in their obstetrical practice in much higher proportions, while fewer physicians from the New England region (25.3%) reported making any of these changes.

Increase in Professional Fees Resulting from Increase in Malpractice Premiums (Tables 29-30)

o Overall, the vast majority (82.9%) of physicians reported that the increase in the cost of malpractice insurance had directly affected their professional fees. There was some regional variation, however: Whereas 94.7 percent and 93.8 percent of physicians in the Florida and New York regions, respectively, said that their fees had been directly affected by malpractice insurance costs, relatively fewer physicians in the Great Lakes and Mid South regions reported that their fees had been directly affected by insurance costs (73.0% and 71.7%, respectively).

o For those respondents who indicated their fees had increased due to increases in malpractice premiums since 1983, the most commonly reported increases were between 6-10 percent (28.3%) and 11-15 percent (21.7%). Although the pattern of percentage increases in fees was generally consistent across regions, physicians in the New York region more frequently reported higher percentage increases.

ACOG2

TABLE 1: SEX OF RESPONDENT

	TOTAL	REGION New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Male	93.0	92.8	87.2	91.4	93.4	94.9	91.2	96.2	96.8	92.0	91.2
Female	7.0	7.2	12.8	8.6	6.6	5.1	8.8	3.8	3.2	8.0	8.8

ACOG2

TABLE 2: AGE OF RESPONDENT

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Mo.	Mid So.	West	Ca.	Fla.
Less than 35	2.5	4.5	1.5	2.9	3.1	4.3	0.7	3.3	2.6	0.0	2.9
35 to 44	34.1	34.2	27.8	28.6	32.7	34.1	32.4	38.5	44.2	33.1	34.3
45 to 54	31.3	25.2	28.6	32.4	30.6	27.5	33.1	31.9	26.3	36.4	41.6
55 to 64	24.3	29.7	33.1	23.8	27.0	23.9	28.4	20.9	21.8	19.9	14.6
65 or over	7.9	6.3	9.0	12.4	6.6	10.1	5.4	5.5	5.1	10.6	6.6
Mean	49.6	49.3	51.1	51.2	49.8	49.8	50.1	48.3	48.1	50.1	47.9

ACOG2

TABLE 3: YEARS SPENT IN PRACTICE

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
0-5	7.2	7.2	9.8	8.6	7.3	6.6	4.7	6.6	7.7	6.0	10.3
6-10	23.2	21.6	18.0	19.0	20.7	23.4	21.6	29.1	29.5	24.0	20.6
11-20	32.3	30.6	30.1	24.8	36.8	31.4	33.8	34.6	29.5	31.3	41.2
21-30	24.8	30.6	32.3	30.5	22.8	22.6	27.7	17.6	23.1	26.0	19.1
Over 30	12.5	9.9	9.8	17.1	12.4	16.1	12.2	12.1	10.3	12.7	8.8
Mean	18.1	18.4	18.6	19.9	18.2	18.7	18.6	17.0	16.4	18.4	16.4

TABLE 4: PREDOMINANT TYPE OF PRACTICE

		Region									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Fee for service solo practice	45.2	46.3	55.1	45.5	40.7	44.1	31.4	39.7	48.9	55.2	48.1
Fee/service, specialty group	40.2	34.7	34.7	45.5	50.0	44.1	38.0	42.9	36.6	30.3	41.2
Fee/service, multi-specialty group	6.6	6.3	3.4	2.0	1.1	5.5	23.3	8.1	9.0	3.4	7.6
Salaried employee or other	8.0	12.7	6.8	7.0	8.2	6.3	7.3	9.3	5.5	11.3	3.1

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TABLE 5: GROSS INCOME FROM MEDICAL PRACTICE

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Less than $100,000	13.8	15.5	17.9	16.5	18.2	11.8	9.2	13.3	15.1	9.2	12.9
$100,000-$149,999	21.4	27.8	12.8	26.4	26.7	25.2	27.0	15.7	21.2	17.7	16.9
$150,000-$249,999	30.6	28.9	34.2	29.7	31.8	33.1	35.5	27.1	32.9	27.0	25.8
$250,000 or more	34.2	27.8	35.0	27.5	23.3	29.9	28.4	44.0	30.8	46.1	44.4
Mean	215011	196228	233547	202649	189553	200445	207020	223428	203740	243794	253736

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TABLE 6: PERCENTAGE OF PRACTICE DEVOTED TO OBSTETRICS

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
25 percent or less	23.2	25.3	19.0	24.5	25.7	19.0	20.0	27.0	17.4	24.4	32.3
26-50 percent	45.1	48.5	42.1	45.1	50.3	44.7	47.6	38.0	52.0	45.9	37.8
51-75 percent	26.8	21.4	36.5	26.5	18.6	31.1	29.7	29.8	25.3	23.6	23.6
76-100 percent	4.8	4.9	2.4	3.9	5.5	5.3	2.8	5.3	5.3	6.1	6.3

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TABLE 7: PHYSICIANS NOT PRACTICING OBSTETRICS

Subsample: Respondents who do not practice obstetrics

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Never practiced	6.8	0.0	18.2	0.0	12.5	6.7	9.1	4.5	0.0	10.0	8.3
Stopped during career	93.2	100.0	81.8	100.0	87.5	93.3	90.9	95.5	100.0	90.0	91.7

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TABLE 6: AGE AT WHICH PHYSICIANS STOPPED PRACTICING OBSTETRICS

Subsample: Respondents who stopped practicing obstetrics during career

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Mo.	Mid So.	West	Ca.	Fla.
Before age 35	2.8	7.1	0.0	6.3	0.0	0.0	0.0	4.8	0.0	0.0	9.1
Between 35 and 44	22.5	42.9	22.2	18.8	19.0	7.1	10.0	33.3	25.0	11.1	40.9
Between 45 and 54	28.9	28.6	11.1	18.8	47.6	35.7	40.0	38.1	31.3	16.7	13.6
Between 55 and 64	30.7	7.1	33.3	37.5	23.8	50.0	40.0	19.0	25.0	44.4	22.7
Age 65+	15.1	14.3	33.3	18.8	9.5	7.1	10.0	4.8	18.8	27.8	13.6

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TABLE 9: AVERAGE NUMBER OF DELIVERIES PERFORMED PER MONTH

Subsample: Physicians who deliver babies

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
1-7	20.8	18.2	34.5	17.4	28.5	14.5	19.5	13.1	19.4	24.0	18.4
8-12	36.5	34.1	39.8	33.7	38.4	32.5	35.3	37.9	30.6	40.0	41.8
13-19	25.2	28.4	18.6	30.2	24.5	31.6	22.6	24.1	25.4	23.2	25.5
20 or more	17.5	19.3	7.1	18.6	8.6	21.4	22.6	24.8	24.6	12.8	14.3

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TABLE 10: PERCENTAGE OF OBSTETRICAL PRACTICE DEVOTED TO HIGH-RISK CARE

Subsample: Physicians who practice obstetrics

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Mo.	Mid So.	West	Ca.	Fla.
10 percent or less	1.6	2.3	0.9	0.0	1.9	0.0	0.8	3.4	0.8	2.4	4.0
11-20 percent	50.1	39.1	47.4	60.5	51.6	53.8	51.5	46.6	46.6	50.0	50.0
21-30 percent	25.1	35.6	26.3	19.8	25.5	23.9	25.0	21.9	29.0	25.8	24.0
30 percent or more	23.2	23.0	25.4	19.8	21.0	22.2	22.7	28.1	23.7	21.8	22.0

TABLE 11: COVERAGE BY PROFESSIONAL LIABILITY INSURANCE

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Yes	98.1	100.0	100.0	99.0	99.0	98.5	98.6	97.8	98.1	96.0	92.0
No	1.9	0.0	0.0	1.0	1.0	1.5	1.4	2.2	1.9	4.0	8.0

TABLE 12: LIMITS OF PRIMARY COVERAGE PER CLAIM

Subsample: Respondents covered by liability insurance

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Under $250,000	23.2	5.2	2.5	47.8	14.9	72.3	25.6	24.2	8.2	5.8	16.2
$250,001-$500,000	10.1	10.4	3.3	6.5	4.0	10.1	9.6	13.0	6.0	15.7	31.6
$500,001-$1,000,000	52.4	66.7	90.0	38.0	53.4	15.1	50.4	47.8	49.3	68.6	48.7
$1,000,001-$3,000,000	10.9	12.5	4.2	7.6	20.7	1.7	8.8	11.8	27.6	7.4	3.4
Over $3,000,000	3.4	5.2	0.0	0.0	6.9	0.8	5.6	3.1	9.0	2.5	0.0

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TABLE 13: COST OF PRIMARY INSURANCE COVERAGE IN 1984

Subsample: Respondents who are covered by liability insurance

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid Wo.	Mid So.	West	Ca.	Fla.
Less than $8,000	13.8	6.0	3.2	6.1	19.9	27.6	14.2	26.2	6.6	6.3	6.6
$8,000-$14,999	28.5	34.0	3.2	12.1	33.7	47.2	21.6	50.6	31.4	21.9	7.4
$15,000-$24,999	30.6	42.0	16.0	66.7	35.4	21.3	30.6	20.0	37.2	23.4	18.0
$25,000-$34,999	15.2	11.0	24.0	11.1	6.1	2.4	17.9	2.5	20.4	35.2	39.3
$35,000 or more	11.9	7.0	53.6	4.0	5.0	1.6	15.7	0.6	4.4	13.3	28.7
Mean	20818	19836	38153	19429	16046	11949	23025	16507	18353	22756	30805

TABLE 14: HAS ANNUAL PREMIUM INCREASED SINCE 1983

Subsample: Respondents covered by liability insurance

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Yes	92.8	94.3	97.6	97.0	96.2	91.5	98.6	85.8	94.4	85.0	96.0
No	7.2	5.7	2.4	3.0	3.8	8.5	1.4	14.2	5.6	15.0	4.0

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TABLE 15: AMOUNT THAT ANNUAL PREMIUM HAS INCREASED SINCE 1983

Subsample: Respondents whose annual premiums have increased

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Less than $4,000	21.4	12.7	6.0	17.6	26.1	40.7	13.9	38.6	14.0	16.3	2.3
$4,000-$7,999	31.4	49.3	7.1	48.6	28.2	29.7	19.8	39.5	38.6	33.7	8.0
$8,000-$12,999	23.4	25.4	20.2	23.0	19.0	14.3	22.8	16.7	26.3	39.1	37.5
$13,000 or more	23.9	12.7	66.7	10.8	26.8	15.4	43.6	5.3	21.1	10.9	52.3
Mean	9871	7753	21635	7091	9380	7418	13361	5199	9056	7922	17131

TABLE 16: COSTS OF PRIMARY COVERAGE AS PERCENTAGE OF GROSS INCOME

Subsample: Respondents covered by liability insurance

		Region									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Mean gross income*	215011	196228	233547	202649	189553	200445	207020	223428	203740	243794	253736
Mean cost of primary coverage	20818	19836	38153	19429	16046	11949	23025	16507	18353	22756	30805
Percentage of gross income	9.7	10.1	16.3	9.6	8.5	6.0	11.1	7.4	9.0	9.3	12.1

*Based on entire sample

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TABLE 17: HAS PROFESSIONAL LIABILITY CLAIM EVER BEEN FILED

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Yes	73.0	82.7	81.2	86.7	64.9	77.4	74.3	67.0	68.6	65.6	72.9
No	27.0	17.3	18.8	13.3	35.1	22.6	25.7	33.0	31.4	34.4	27.1

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TABLE 18: NUMBER OF CLAIMS FILED

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Zero	27.4	17.3	20.0	13.6	35.1	22.8	25.7	33.1	32.0	35.3	27.3
1 claim	24.5	30.9	14.6	26.2	33.5	24.3	20.3	28.2	30.1	13.3	25.8
2 claims	19.5	26.4	16.9	13.6	16.0	18.4	21.6	23.2	20.9	19.3	22.0
3 or more claims	28.5	25.5	48.5	46.6	15.5	34.6	32.4	15.5	17.0	32.0	25.0

TABLE 19: PRIMARY ALLEGATIONS OF MALPRACTICE CLAIMS -- PERCENT OF TOTAL CLAIMS FILED

Subsample: Respondents who have experienced liability claims

	Region										
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Brain damage/injury to infant	20.4	21.6	30.2	18.0	16.6	21.1	19.9	21.6	13.3	19.2	13.0
Stillbirth/infant death	6.4	5.9	1.8	5.9	9.2	6.1	5.1	10.3	5.9	7.3	8.7
Diagnosis related-OB	5.4	7.0	6.8	3.8	3.7	4.5	6.1	7.8	6.4	3.4	5.3
Diagnosis related-GYN	11.6	10.8	12.0	13.4	14.3	10.2	15.2	7.8	10.3	10.0	13.6
Maternal injury	6.3	4.9	6.8	6.3	8.8	4.9	5.1	4.3	8.9	6.9	8.2
Maternal death	3.1	3.2	3.1	1.7	4.6	2.4	2.9	3.4	3.0	3.4	3.9
Patient injury-GYN	28.9	29.2	21.5	35.1	23.0	29.7	27.1	26.7	33.5	35.6	25.1
Patient death-GYN	2.2	1.1	2.5	2.1	0.9	2.4	2.5	2.2	2.5	1.9	4.8
Failure of sterilization	7.0	5.9	6.5	7.1	7.8	7.7	7.6	8.6	7.4	5.0	5.8
Other	8.6	10.3	8.0	6.7	11.1	11.0	8.7	7.3	8.9	7.3	10.1
Pregnancy termination	.2	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.4

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TABLE 20: LENGTH OF TIME BETWEEN INCIDENT AND FILING OF CLAIM

Subsample: Respondents who have experienced liability claims

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Less than 6 months	10.4	7.7	5.6	8.8	8.7	10.4	10.0	8.2	18.7	14.1	16.5
More than 6 months but less than 1 year	19.1	19.8	15.7	16.5	17.5	24.5	18.2	19.7	13.1	27.3	12.4
More than 1 year but less than 3 years	33.1	31.9	22.2	49.5	32.5	31.1	30.9	32.8	31.8	28.3	44.3
More than 3 but less than 5 years	4.7	2.2	5.6	4.4	7.1	0.9	5.5	3.3	10.3	5.1	3.1
More than 5 years	4.5	2.2	7.5	5.5	4.8	3.9	3.6	2.4	3.9	8.1	0.0
Don't know	28.3	36.3	43.5	15.4	29.4	29.2	31.8	33.6	22.4	17.2	23.7

TABLE 21: EXPERIENCE WITH COMPLETED PROFESSIONAL LIABILITY CLAIMS

Subsample: Respondents who have experienced liability claims

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Yes	71.1	63.7	57.7	82.0	67.8	68.3	69.4	66.1	78.4	83.3	76.6
No	28.9	36.3	42.3	18.0	32.2	31.7	30.6	33.9	21.6	16.7	23.4

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TABLE 22: STATUS OF INSURANCE CLAIM

Subsample: Respondents with completed liability claims

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Settled	64.3	72.4	69.0	70.0	51.7	61.6	63.6	58.8	69.0	70.4	55.9
Contested	28.6	25.9	22.4	20.0	37.9	30.1	32.5	33.7	26.4	23.5	38.2
Settled without payment	7.1	1.7	8.6	10.0	10.3	8.2	3.9	7.5	4.6	6.2	5.9

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TABLE 23: LENGTH OF TIME BETWEEN FILING AND SETTLING OF CLAIM

Subsample: Respondents whose claims were settled

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Less 6 months	12.7	10.5	2.6	12.5	17.1	15.9	16.7	10.9	20.6	7.1	18.9
More than 6 months but less than a year	18.0	10.5	7.7	18.9	9.8	20.5	16.7	28.3	22.4	19.3	16.2
More than 1 year but less than 2 years	23.0	21.1	15.4	16.7	29.3	25.0	18.8	21.7	25.9	26.3	40.5
More than 2 years, less than 5 years	37.1	44.7	46.2	45.8	41.5	36.4	35.4	30.4	24.1	38.6	18.9
More than 5 years	9.2	13.2	28.2	6.3	2.4	2.3	12.5	8.7	6.9	8.8	5.4

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TABLE 24: AMOUNT PAID ON PHYSICIAN'S BEHALF TO SETTLE CLAIM

Subsample: Respondents who settled claim

		Region									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Nothing paid	11.1	2.5	12.8	14.6	18.4	13.3	6.3	13.3	6.9	9.1	9.8
Less than $5,000	12.9	7.5	5.1	6.2	12.2	20.0	8.3	15.6	22.4	14.5	17.1
$5,000-$19,999	23.0	30.0	20.5	25.0	18.4	13.3	25.0	26.7	29.3	23.6	14.6
$10,000-$99,999	28.3	22.5	33.3	31.3	24.5	35.6	27.1	22.2	19.0	34.5	29.3
$100,000-$999,999	20.0	37.5	23.1	18.8	20.4	13.3	22.9	17.9	17.2	14.5	29.3
$1,000,000 or more	4.6	0.0	5.1	4.2	6.1	4.4	10.4	4.4	5.2	3.6	0.0
Mean	178,567	186,019	134,855	131,968	176,400	132,964	299,455	131,435	160,903	262,677	116,878
Median	30,000	40,000	50,000	30,000	35,000	27,000	45,000	20,000	15,000	30,000	54,000

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TABLE 25: LENGTH OF TIME BETWEEN FILING OF CLAIM AND OUTCOME OF CONTESTED CASE

Subsample: Respondents whose claims were contested

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Less than 6 months	4.7	0.0	0.0	0.0	6.0	0.0	4.8	7.6	13.0	0.0	15.3
More than 6 months, less than 1 year	14.6	33.3	15.4	0.0	27.3	13.6	4.8	19.2	13.0	5.3	11.5
More than 1 year, less than 2 years	25.6	26.7	0.0	42.9	24.2	27.3	28.6	26.9	39.1	10.5	26.9
More than 2 years, less than 5 years	44.4	40.0	61.5	42.9	27.3	45.5	38.1	46.2	34.8	68.4	46.2
More than 5 years	10.7	0.0	23.1	14.3	15.2	13.6	23.8	0.0	0.0	15.8	0.0

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TABLE 26: OUTCOME OF CONTESTED CASE

Subsample: Respondents who have contested a case

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Won	80.9	73.3	61.5	71.4	87.9	86.4	80.0	85.2	82.6	84.2	76.9
Lost	15.1	20.0	23.1	21.4	12.1	13.6	12.0	14.8	13.0	15.8	11.5
Case was dropped	4.0	6.7	15.4	7.1	0.0	0.0	8.0	0.0	4.3	0.0	11.5

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TABLE 27: PERCENT RESPONDING THAT INCREASE IN MALPRACTICE SUITS INCREASED SPECIFIC ACTIVITIES IN PRACTICE

		Region									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Provide written or taped information to patients	49.1	39.7	43.1	54.9	46.3	43.7	47.9	50.0	50.6	59.0	43.3
Obtain written informed consent	43.1	46.6	42.1	41.1	37.5	36.1	31.1	46.8	42.0	61.5	37.1
Explain potential risks of recommended procedures	54.4	65.5	67.2	68.5	54.3	50.0	66.4	73.4	59.3	74.4	54.3
Document other activities	68.2	69.0	72.4	68.5	66.7	62.5	66.2	72.2	66.7	67.9	71.4
Referrals to other physicians	37.0	36.8	50.0	38.0	37.8	34.3	25.7	35.9	39.5	37.2	35.2
Consultation with other physicians	44.2	44.8	48.3	47.9	37.0	42.3	37.8	44.9	48.8	46.2	42.0
Testing and diagnostic procedures	67.8	58.6	77.6	71.2	62.2	67.6	70.3	64.1	61.7	73.1	68.1
Monitoring procedures	58.8	50.0	67.2	60.6	56.3	52.1	56.2	59.2	61.3	62.3	60.6
Staff presence at examinations	13.6	10.5	21.1	12.7	13.8	10.1	4.1	14.3	14.8	15.4	22.7
Other	31.9	16.7	40.0	28.6	50.0	26.7	11.1	30.8	33.3	40.0	30.0

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TABLE 28: CHANGES IN PERSONAL PRACTICE AS A RESULT OF THE RISK OF MALPRACTICE

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Decreased number of deliveries	13.7	6.8	16.5	10.4	13.7	21.7	11.0	11.0	10.7	15.5	19.7
Decreased high-risk obstetrical care	23.1	10.7	29.9	21.9	15.4	31.9	25.0	16.3	16.1	33.8	30.7
No longer practice obstetrics	12.3	15.5	8.7	14.6	13.2	13.2	7.4	12.2	9.4	11.3	24.4
Decreased gynecological surgery	6.9	2.9	11.0	7.3	9.3	10.9	7.4	2.3	4.0	6.3	7.9
No longer do gynecological surgery	3.3	2.9	3.1	6.2	4.4	6.2	1.5	2.3	2.7	0.7	3.1
No changes in personal practice	62.9	71.8	55.9	59.4	65.9	53.5	70.6	70.9	71.1	57.7	44.1
Made any changes in obstetrical practice	35.0	25.3	39.9	37.1	30.6	44.9	27.7	27.9	27.6	42.4	53.3

ACOG2

TABLE 29: PROFESSIONAL FEES AFFECTED BY INCREASE IN COST OF PROFESSIONAL LIABILITY INSURANCE

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
Yes	82.9	76.9	93.8	84.6	84.9	73.0	89.0	71.7	88.7	84.1	94.7
No	17.1	23.1	6.2	15.4	15.1	27.0	11.0	28.3	11.3	15.9	5.3

ACOG2

TABLE 30: ESTIMATE OF INCREASE IN PROFESSIONAL FEES RESULTING FROM INCREASES IN MALPRACTICE PREMIUMS SINCE 1983

Subsample: Respondents whose annual premiums have increased

		REGION									
	TOTAL	New Eng.	New York	Mid Atl.	So. East	Grt Lks.	Mid No.	Mid So.	West	Ca.	Fla.
0-5%	11.1	9.0	1.7	11.4	6.4	23.4	9.8	16.9	12.5	12.7	4.2
6-10%	28.3	32.1	12.8	25.0	25.6	34.0	31.7	36.3	31.2	33.1	16.0
11-15%	21.7	17.9	12.8	27.3	28.2	17.0	22.0	21.8	24.2	21.2	21.0
16-20%	13.4	19.2	16.2	14.8	10.9	9.6	10.6	12.1	13.3	12.7	21.0
21-25%	11.2	9.0	18.8	11.4	13.5	6.4	13.0	7.3	8.6	9.3	16.8
26-30%	6.2	5.1	11.1	4.5	8.3	4.3	6.5	3.2	5.5	4.2	10.9
31-35%	2.8	3.8	6.8	2.3	1.9	2.1	4.1	0.8	3.1	1.7	2.5
36-40%	3.3	3.8	14.5	1.1	1.9	1.1	1.6	0.8	1.6	3.4	4.2
Over 40%	2.0	0.0	5.1	2.3	3.2	2.1	0.8	0.8	0.0	1.7	3.4

APPENDIX

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dear Colleague:

Professional liability and its costs have been key concerns for the practice of obstetrics and gynecology for the past decade. Professional liability insurance has again assumed crisis proportions, both in affordability and availability.

As this issue is addressed by medicine and legislators at the state and national level, we have greater need for accurate data. We recognize that you recently received a College survey on practice management, and apologize for submitting another so soon. By using the same sample of our Fellowship, our information on professional liability is enhanced by the demographic data obtained in the earlier survey. Please complete and return this survey **even if you did not complete** the survey on practice management. The validity and credibility of our data is greatly affected by the response rate we achieve.

To better serve you, we again need your time and cooperation to complete this questionnaire. We urge your early response.

Sincerely,

Keith C White

Keith C. White, M.D., FACOG
Director
District and Section Activities

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

SURVEY OF PROFESSIONAL LIABILITY

INTRODUCTION

Thank you for participating in the Professional Liability survey. Your responses to the survey will be **completely confidential.** No one from the College will have access to the returned questionnaires. Questionnaires are being sent directly to Needham Porter Novelli for analysis, and findings will be reported in grouped form only.

Please read the questionnaire carefully. Most questions call for only **one** answer unless specified otherwise. For each question circle the most appropriate answer or fill in the blank. Some questions have two parts depending upon your answer. If you select the "other" response for a question, please specify the nature of your answer.

Given the scientific nature of the sample, it is very important that you complete the questionnaire and return it in the enclosed stamped envelope **within 10 days.**

Thank you for your time and effort in this very important matter.

Section I

First, we would like you to answer some questions concerning you and your type of practice. This information will be important in analyzing responses to later items.

1. Are you currently practicing medicine?

   1. Yes
   2. No
   (If no, **do not continue. Please return blank questionnaire** in the envelope provided. Thank you.)

1a. If you are currently in private practice, is your predominant type of practice: (Circle only **one**)

   1. Fee for service, **solo practice**
   2. Fee for service, **single specialty** partnership or group practice (How many physicians are in your partnership or group? ______)
   3. Fee for service, **multispecialty** partnership or group (What specialties other than OB/GYN are in your practice? ______________________________ ______________________________ ______________________________)
   4. **Salaried employee** of fee for service practice
   5. **Salaried employee** of Health Maintenance Organization, hospital, etc.
   6. Other (please specify: ______________________________)

2. Age: ______ years

3. Sex: 1. Male
   2. Female

4. How many years have you been in practice (not including residency)? ______ years

5. Please specify the state in which your practice is located:

____

6. Approximately what was your total gross income from medical practice in 1984? $ ______________________

7. Approximately what percent of your practice is (Percents should add to 100%):

a. obstetrics ____% If 0% obstetrics, ANSWER QUESTION 7a

b. gynecology ____%

100%

7a. If you currently do not practice obstetrics **at all**, did you: (Circle only **one**)
   1. Never practice obstetrics
   2. Stop at age ______ (specify age)

8. On average, how many deliveries do you personally perform per month? ______ (Please specify a number)

9. Of your **obstetrical practice**, what percent of your patients would be considered high risk: ______ %

10. Of your **gynecology-related practice**, what percent is spent on well-patient care: ______ %

11. Which of the following full- or part-time staff positions exist in your office? (Circle **all** that apply)

   1. RN
   2. Nurse practitioner
   3. Nurse midwife
   4. LPN
   5. Lab Technician
   6. Office Manager
   7. Billing clerk
   8. Receptionist or other office personnel
   9. Other (Specify): ______________________________ ______________________________

Section 2

The next section deals with questions regarding professional liability insurance.

12. Are you covered by professional liability (malpractice) insurance?

    1. Yes (SKIP TO QUESTION 13)
    2. No

    12a. What is the major reason you decided not to have professional liability insurance? (Circle only one)

        1. Don't need it
        2. Can't afford it
        3. Philosophically opposed to it
        4. Not available at any price
        5. Available, but limits offered are too low to retain my hospital privileges
        6. Other (Specify): ________________________
        ____

    12b. How long have you been without professional liability insurance?

        1. Less than 6 months
        2. Between 6 months and a year
        3. 1–5 years
        4. More than 5 years

13. Have you ever changed liability insurance companies?

    1. Yes
    2. No (SKIP TO QUESTION 14)

    13a. How many times have you changed? ________ (Specify a number)

    13b. What were the major reasons for the change? (Circle all that apply)

        1. State or area regulations
        2. Old company no longer offers insurance
        3. Old company dropped my coverage
        4. New company is less expensive
        5. The limits offered by the old company were too low to retain my hospital privileges
        6. Switched type of insurance (claim-made; occurrence)
        7. Other (Specify): ________________________

14. Do you have a choice regarding the amount of liability insurance coverage you can get? (Circle only one)

    1. Yes
    2. No, because of state regulations
    3. No, because of hospital regulations
    4. No, because I am not involved in the decision
    5. No, because of economic considerations
    6. No, because of insurance company regulations
    7. No, other (Specify): ________________________

15. Do you have a choice regarding the carrier of your primary coverage?

    1. Yes
    2. No
    3. Don't know

16. What kind of professional liability insurance policy do you have?

    1. Occurrence
    2. Claims-made
    3. Don't know

17. What are the limits of your primary coverage? (Specify amount to nearest dollar)

    $________________ per claim

    $________________ aggregate

    ________ don't know (please check)

18. Approximately what was the annual cost of your primary coverage in 1984? (Specify amount to nearest dollar)
    $ ________________

19. Do you carry excess/umbrella/patient compensation fund coverage?

    1. Yes
    2. No (SKIP TO QUESTION 20)
    3. Don't know (SKIP TO QUESTION 20)

    19a. How much excess coverage? $________________ (Specify amount to nearest dollar)

    19b. What is the annual cost? $________________ (Specify amount to nearest dollar)

    19c. Is the excess coverage required by state or hospital regulation? (Circle all that apply)

        1. Yes, by the state
        2. Yes, by the hospital
        3. No
        4. Don't know

20. Approximately what percentage of your gross income from medical practice does your total professional liability premium represent? ________ %

21. Other than premium costs, have you incurred any other financial costs, such as additional annual assessments, as a direct result of possessing professional liability insurance?

    1. Yes
    2. No (SKIP TO QUESTION 22)
    3. Don't know (SKIP TO QUESTION 22)

    21a. What are these other financial costs? ________________________
    ____

22. Since 1983 has your annual premium increased?

    1. Yes
    2. No (SKIP TO QUESTION 23)

    22a. How much has it increased since 1983? (Specify amount to nearest dollar) $ ________________

    22b. When was the most recent increase?
    ________ month(s) ago (Specify a number)

Section 3

The final section of the questionnaire focuses on experience with professional liability claims.

23. Have you ever had a professional liability (medical malpractice) claim filed against you?

1. Yes
2. No (SKIP TO QUESTION 51)

24. How many claims have been made against you? (Specify number of claims) ______

25. Below is a list of allegations that could form the basis or bases for a malpractice claim. For each claim filed against you, please enter the 2-digit code that identifies the specific allegation that formed the primary and secondary basis for each claim. (Enter 2-digit code numbers from the list in the appropriate spaces below for as many claims as you have experienced.)

2-Digit Code	
01	Brain damage/Injury to infant
02	Stillbirth/Infant death
03	Diagnose-related—Obstetrical
04	Diagnose-related—Gynecological
05	Maternal injury
06	Maternal death
07	Patient injury—Gynecological
08	Patient death—Gynecological
09	Failure of sterilization
10	Other (please specify where entered)

25a. Claim #1 primary: ______
secondary: ______

25b. Claim #2 primary: ______
secondary: ______

25c. Claim #3 primary: ______
secondary: ______

25d. Claim #4 primary: ______
secondary: ______

25e. Claim #5 primary: ______
secondary: ______

25f. Claim #6 primary: ______
secondary: ______

26. Have you experienced any completed professional liability claims?

1. Yes
2. No (SKIP TO QUESTION 50)

Please think about the **completed** professional liability claim you consider most **serious** or **significant.** Answer questions 27 through 49 with reference to that particular claim.

27. What were the specific allegations which were the primary and secondary bases of this particular claim? (Enter the 2-digit code numbers from the list below. If "Other," please specify.)

2-Digit Code	
01	Brain damage/injury to infant
02	Stillbirth/Infant death
03	Diagnose-related—Obstetrical
04	Diagnose-related—Gynecological
05	Maternal injury
06	Maternal death
07	Patient injury—Gynecological
08	Patient death—Gynecological
09	Failure of sterilization
10	Other (please specify where entered)

Primary allegation: ______

Secondary allegation(s): ______
______
______

28. In what year was the claim initiated, i.e., officially filed?

19______ (Specify year)

29. Aside from yourself, were there any other individuals or institutions named in the suit?

1. Yes
2. No (GO TO QUESTION 30)

29a. Who else was named? (Circle all that apply)

1. My partner(s)
2. Other physicians
3. Nurse(s)
4. Nurse midwife (wives)
5. Hospital
6. Clinic
7. Free-standing birthing center
8. Other (Specify): ______________________

30. What was your professional relationship to the patient?

1. I was the patient's attending physician
2. The patient's physician was my partner or member of my group practice
3. I served as a consultant in the case
4. I was the department chairman or on the teaching staff
5. Other (Specify): ______________________

31. In what kind of setting did the incident that served as the basis for the claim occur?

1. Office
2. Hospital
3. Patient's home
4. Clinic
5. Free-standing birthing center
6. Other (Specify): ______________________

32. How long was it between the time that the incident occurred and when the official claim was filed?

1. Less than a month
2. More than a month but less than 6 months
3. More than 6 months but less than a year
4. More than a year but less than 3 years
5. More than 3 years but less than 5 years
6. More than 5 years but less than 10 years
7. More than 10 years but less than 15 years
8. Fifteen years or more
9. Don't know

33. Did you have professional liability insurance for the period covering the incident on which the claim was based?

1. Yes
2. No (SKIP TO QUESTION 37)

34. How did your insurance company react to the claim? (Circle all that apply)

1. Suggested an immediate settlement (ANSWER QUESTION 34a)
2. Discussed the case with me
3. Examined my medical records
4. Carried on an evaluative procedure
5. Informed me that my insurance would be affected
6. Other (Specify): ______________________

____

34a. Did a settlement occur at this point?

1. Yes
2. No (SKIP TO QUESTION 35)

34b. Did you consent to the settlement?

1. Yes (SKIP TO QUESTION 39)
2. No (SKIP TO QUESTION 39)

35. Did your insurance company bring a defense attorney in on the claim?

1. Yes
2. No (GO TO QUESTION 37)
3. Don't know

35a. When was the attorney first brought in on the claim? (Circle only one)

1. Immediately
2. After initial discussion and evaluation
3. During the discovery process
4. Other (Specify): ______________________

____

36. At any point, did you request a change of the defense attorney assigned by the insurance company?

1. Yes
2. No (SKIP TO QUESTION 37)

36a. What action was taken on your request?

1. A new attorney was assigned to my case
2. The insurance company refused to assign a new attorney
3. Other (Specify): ______________________

____

____

37. Did you personally hire your own attorney?

1. Yes
2. No (GO TO QUESTION 38)

37a. Why did you personally hire an attorney? (Circle all that apply)

1. The insurance company did not immediately bring in an attorney
2. I did not like the insurance company's attorney
3. I felt I needed additional protection
4. The insurance company recommended it
5. Other physicians I know suggested that I do so
6. I didn't have an insurance company representing me (no professional liability insurance)
7. Other (Specify): ______________________

____

38. Was the claim settled or was it contested to a final conclusion?

1. Settled   Year settled: 19______
2. Contested (SKIP TO QUESTION 41)

39. How much was paid on your behalf to settle the claim? (Specify amount to nearest dollar) $ ____________

40. How long was it between when the claim was filed and settlement reached?

1. Less than a month
2. More than a month but less than 3 months
3. More than 3 months but less than 6 months
4. More than 6 months but less than 1 year
5. More than 1 year but less than 2 years
6. More than 2 years but less than 5 years
7. More than 5 years

SKIP TO QUESTION 43 IF A SETTLEMENT WAS REACHED WITHOUT FURTHER CONTEST.

41. Given that the case was contested to a conclusion, what was the outcome?

1. I won (SKIP TO QUESTION 42)
2. I lost

41a. How much was paid on your behalf as a result of the outcome? (Specify amount to nearest dollar)
$ ____________

42. How long was it between when the claim was filed and the outcome reached?

1. Less than a month
2. More than a month but less than 3 months
3. More than 3 months but less than 6 months
4. More than 6 months but less than 1 year
5. More than 1 year but less than 2 years
6. More than 2 years but less than 5 years
7. More than 5 years

43. What was your initial opinion of the claim?

1. There was some legitimate question regarding the medical procedure(s) used
2. It was a bad medical outcome but not malpractice
3. Other (Specify): ______________________

____

44. How do you feel about the way this claim was handled by the insurance company?

1. Very satisfied
2. Moderately satisfied
3. Neither satisfied nor dissatisfied
4. Moderately dissatisfied
5. Very dissatisfied
6. Insurance company did not handle claim

45. Based on this particular medical malpractice experience, what was your general opinion about the legal process?

1. It was generally fair
2. It was generally unfair
3. No opinion

46. Based on this particular medical malpractice experience, what was your opinion of your attorney?

1. Very satisfied
2. Moderately satisfied
3. Neither satisfied nor dissatisfied
4. Moderately dissatisfied
5. Very dissatisfied
6. No attorney was involved on my behalf

47. Did the insurance company make any changes in your insurance as a result of this claim?

1. Yes
2. No (SKIP TO QUESTION 48)

47a. What kind(s) of changes were made? (Circle all that apply)

1. Increased my premiums
2. Forced an increase in the amount of insurance I need to carry
3. Terminated my insurance
4. Other (Specify): ____________________

48. Did you change your insurance in any way?

1. Yes
2. No (SKIP TO QUESTION 49)

48a. What kind of change(s) did you make? (Circle all that apply)

1. Increased my coverage
2. Decreased my coverage
3. Changed insurance company
4. Terminated coverage altogether
5. Other (Specify): ____________________

49. Which of the following outcomes, if any, have you experienced as a result of this claim? (Circle all that apply)

1. Disruption in family life
2. Adverse effect on relations with other physicians
3. Adverse effect on hospital relations
4. Decreased enjoyment in the practice of medicine
5. Public embarrassment
6. Increased awareness of the patient's involvement in medical decisions
7. Stress (e.g., anxiety, depression)
8. Other (Specify): ____________________
9. None of the above or any others that I can think of

50. As a result of your professional liability claim experience(s), has your practice changed the frequency with which any of the following activities are performed?
(Circle one number for each activity)

	My practice has not changed	My practice has increased this activity	My practice has decreased this activity	Does not apply to my practice/ have never performed this activity
a. Provide written or taped information to patients	1	2	3	4
b. Obtain written informed consent	1	2	3	4
c. Explain potential risks of recommended procedures	1	2	3	4
d. Document other activities (office visits, phone calls, etc.)	1	2	3	4
e. Referrals to other physicians	1	2	3	4
f. Consultations with other physicians	1	2	3	4
g. Testing and other diagnostic procedures (e.g., sedimentation rates, ultra-sound)	1	2	3	4
h. Monitoring procedures	1	2	3	4
i. Staff presence at examinations	1	2	3	4
j. Other (Specify):	1	2	3	4

____

____

51. Have you made any of the following changes in your personal practice as a result of the risk of malpractice? (Circle all that apply)

1. Decreased the number of deliveries
2. Decreased the level of high risk obstetric care
3. No longer practice obstetrics
4. Decreased gynecological surgical procedures
5. No longer do major gynecological surgery
6. Have made no changes in my personal practice

52. Has the increase in the cost of malpractice insurance directly affected your professional fees?

1. Yes (ANSWER QUESTION 53)
2. No

53. What would you estimate is the increase in your professional fees resulting from increases in malpractice premiums since 1983?

1. 0–5%
2. 6–10%
3. 11–15%
4. 16–20%
5. 21–25%
6. 26–30%
7. 31–35%
8. 36–40%
9. over 40% (Please specify ________%)

Thank you very much for your assistance in filling out this survey.

Please use the enclosed stamped envelope to return this survey to the Research Department, Needham Porter Novelli, 3240 Prospect Street, N.W., Washington, D.C. 20007

The **Chairman**. I think the four of you have given excellent testimony here today.

In the interest of time, I am going to submit my questions in writing because I think that will give you time to answer them.

This is an extremely important hearing, and these are real problems. I hear you, Dr. Raum. I can just imagine the women who have relied upon you—and families; husbands, too—have relied upon the rapport and the feeling; and you, Dr. Rydland, and Dr. Gaddy, and Dr. McQuarrie.

I know Dr. McQuarrie pretty well, and he is a great man; and frankly, I hate to see this happen. I hate to see you afraid to practice. But I understand it. You just cannot do it without adequate insurance, and really, there is only so much cost you can pass on to your clients. It is just that simple.

This has been very, very influential testimony to me, and in particular, Dr. McQuarrie, you represented the American College very, very well here today. I want you to know that, and I feel honored to have you here and to have your testimony.

Dr. **McQuarrie**. Thank you.

The **Chairman**. Let me turn to my colleague, Senator Kennedy.

Senator **Kennedy**. Thank you very much.

I appreciate you testimony and I think, as has been pointed out by the witnesses, the ob-gyn function is subject probably to more, or as much in terms of the litigation as any of the other aspects of the medical profession. As I understand, about 60 percent of all ob-gyns have been sued at least once. And we know neurosurgeons are also subject to a good deal of litigation and some of the areas of the profession, for the reasons which have been mentioned earlier during the course of the panel.

So I think there is a recognition that you people are on the firing line.

And I want to say to Dr. McQuarrie, the enormously impressive job that Utah is doing—I am glad to say that in the presence of my colleague—as I understand, your State is No. 1 in the country in terms of reviewing the information in terms of the quality of personnel in the State, and serious medical disciplinary actions, the revocations, suspensions and probations, and your State has been number one in being involved in that. But it certainly indicates what can be done by the medical profession—not that that is going to be the answer to everything

I would like to ask you, though, just briefly—I want to comply with my chairman here, in terms of time—but have any of you seen poor practice yourselves in the profession; and if you have, what have you done about it?

Dr. Raum.

Dr. **Raum**. I do not really think that within the locale where I practice that I have seen poor practice. There are people who do things differently from the way I do them, but not poor practice.

There has been poor practice in some areas near where I did my residency, and the physicians who knew about it very actively tried to have licenses lifted. They went to the department of professional regulation. Florida has also become very aggressive in this respect.

Senator **Kennedy**. OK.

Dr. McQuarrie.

Dr. McQUARRIE. Yes, sir, there is poor practice. And the part of the S. 1804 that leads to identifying those poor practitioners and removing them from practice is appropriate.

There are four elements to that: Providing a stronger Medical Practice Act in each State, providing adequate funding for the process, collecting accurate data for analysis, and finally, there is the delicate issue of indemnity for reporting the problem.

Senator KENNEDY. Thank you.

Dr. Rydland, I would be interested in your response. I heard earlier that 30 percent of your patients are Medicaid patients?

Dr. RYDLAND. In my obstetric practice, about 27 percent of my patients are Medicaid. And that has increased because the physicians in Cumberland, Maryland will no longer accept Medicaid patients.

Senator KENNEDY. I believe that is a national phenomenon. Why is that so?

Dr. RYDLAND. They feel that the reimbursement from West Virginia does not cover what they are paying in malpractice to take care of these patients.

Senator KENNEDY. Well, if we deal with the malpractice, do you think they will start taking those patients?

Dr. RYDLAND. I hope so.

Senator KENNEDY. Well,we might keep that in mind.

Would you just respond quickly and briefly to that other question about whether you saw poor practice or not?

Dr. RYDLAND. I think that in the region that I am in the quality of medical care is very high, and I do not feel that there is anyone that is practicing poorly.

Senator KENNEDY. Thank you.

Dr. Gaddy.

Dr. GADDY. We did have some older physicians that we felt were not keeping up with today's technology and standard of care, and basically what we did was change their status on the medical staff of the hospital and did not give them admitting privileges but allowed them to come by and make courtesy calls on their patients, but had someone else take care of them.

Senator KENNEDY. Just a final question for Dr. Raum. As I understand, the Orlando Sentinel recently conducted a study of claims in Florida malpractice, and they found that 3 percent of the doctors accounted for 48 percent of the malpractice claims paid. And every one of the 3 percent had been sued at least twice and a claim paid. One doctor had paid 34 claims, but was never disciplined for malpractice.

Do you want to make any comment about the Florida system of medical self-discipline?

Dr. RAUM. I am not on that board, so I do not know those cases. And I do not get the Orlando Sentinel, so I did not read that whole series of articles. I wish I could.

Dr. McQuarrie is chairman of that; maybe he could help us out.

Dr. McQUARRIE. Senator Kennedy, perhaps I can just make a generic comment in that reference.

Senator KENNEDY. Fine.

Dr. McQUARRIE. There is a data vacuum in the system. We need better reporting from the insurance carriers; they need to be reported through agencies that can deal with those problems. That is a very sensitive and delicate problem in the process that needs to be corrected, and I think S. 1804 addresses that.

Dr. RAUM. Senator, I do remember one of those instances. As I said, I do not get it, so I had to read it part time. Those are very old cases, many of them. One of the physicians is no longer in the State and does not practice, at least one of them.

Senator KENNEDY. Dr. McQuarrie, in terms of the legislation, do you have recommendations, or do any of you have recommendations on the legislation about where it is deficient, or where you think we might perfect it? Maybe you could just submit that; it would be very, very helpful.

Dr. MCQUARRIE. On behalf of the American College of Obstetricians and Gynecologists, we would be most happy to submit written material as requested.

The CHAIRMAN. We would like to have that.

Let me just ask one question of you, Dr. McQuarrie. What long-term effects will the malpractice crisis have on the practice of obstetrics in this country, in your opinion, representing the college?

Dr. MCQUARRIE. In my opinion, it is going to degenerate the quality of care in obstetrics.

One of the sensitive difficulties, involves physicians like Dr. Raum, who had to withdraw from practice recently. If gone a year or two, because of technological advances, she will never be able to return to her practice. She is permanently lost to the system, a delightful, effective practitioner as she—she will be lost to the system, and that is a desperate loss. So that perhaps puts it in a crisis proportion, because we must do something before our system is completely disrupted.

The CHAIRMAN. Thank you.

Senator METZENBAUM. Let me say I have been very impressed with this panel and their testimony.

Dr. McQuarrie, I would like to ask for some clarification, and maybe you can help us. In your testimony you say that:

> The West Virginia Legislature adopted a comprehensive measure to address the liability insurance problem in that State. Although the law has not yet taken effect, the three major carriers for medical malpractice insurance announced they are cancelling all policies in West Virginia, rather than comply with the provisions of the new law. The Attorney General of West Virginia has filed suit.

Can you give us some information as to what that West Virginia law does or attempts to do?

Dr. MCQUARRIE. I do not know, Senator Metzenbaum.

Perhaps Dr. Rydland can give us—but she has tried and has not been able to. There must have been something oppressive in the law that caused the insurance companies to discontinue.

Senator METZENBAUM. Well, I think we all would agree that there is a major problem, but I think others have indicated—the quote from the Orlando Sentinel, which did a very extensive series of articles, "Doctors' errors can have deadly consequences and paralyzing results, errors that come back to haunt." It is just a whole series of separate articles. One conclusion they reach at one point is that, "Many doctors have continued making mistake after mistake because colleagues, hospitals or medical societies look the other way while State regulators do little to break the cycle."

I think some States in the Union are down to four-tenths of 1 percent or four-one-hundredths of 1 percent. Utah, as Senator Kennedy pointed out, has the best record in the country of bringing actions or raising issues with respect to those who practice in the medical field.

It seems to me that that is an absolute must, and without that, no matter what we do or anybody else does, if doctors continue to perform actions that constitute malpractice, and if the profession itself does not come down on them, nobody's bill is going to solve the problem, because the people are going to pay the penalty. We can limit the monetary damages, but that does not solve the problem of the people who have to suffer through the balance of their lives; and whether you give them a quarter of a million dollars, as the chairman's bill would do as a maximum for pain and suffering, or you give them $5 million, they still go through the suffering, and we have still got doctors who would continue to create those problems with or without insurance.

Would you care to comment at all, Dr. McQuarrie?

Dr. McQuarrie. I can only share your concerns. We recognize our responsibility, and we are willing to address it. This is too delicate and sensitive a societal issue not to take our own responsibility in that respect.

Senator Metzenbaum. Well, I commend you for being here and speaking out on behalf of the American College of Obstetricians and Gynecologists. So often we get those who appear before our committee who are totally protective or defensive. I think you have come forward with a very realistic approach and willingness to work with the committee, and I know I look forward to working with you to see whether we can fashion some legislation, not necessarily that which the chairman has proposed, but perhaps some legislation that could adequately deal with the problem.

I think Dr. Rydland is trying to say something.

Dr. Rydland. I just want to say, Senator Metzenbaum, that I have included with my testimony the letters that I received from my malpractice insurance carriers, and the only explanations I have received are in those letters. So they are available to you, and you can see what they are telling the doctors in West Virginia, which they do not really explain exactly why.

Senator Metzenbaum. I will have a member of the staff pick them up so that I can take a look at them.

Dr. Rydland. All right, thank you.

Senator Metzenbaum. But Dr. Rydland, I do not want you to go away from this hearing with any negative feeling. I do want to tell you—I know you are in the field of maternal and child health programs—and I am sure you will be pleased to know that, notwithstanding the cutbacks of Gramm-Rudman, we have been able to provide out of the Senate $75 million extra for maternal and child health programs. At least maybe that will help a little bit in continuing to provide services for mothers and their children.

Dr. Rydland. It is helping to provide services to women who otherwise would not have care in West Virginia, and we do thank you for that.

Senator Metzenbaum. Thank you.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator.

Senator Simon.

Senator **Simon**. Mr. Chairman, first I want to thank you. The last time we had a meeting, we discussed getting something going on the Civil Rights Extension Act, and I want to express my public appreciation for your staff's willingness, at your direction, to sit down and work with us and see if we cannot get something done.

The **Chairman**. We are trying to do it. Thank you. I appreciate your work on it, too.

Senator **Simon**. Second, I am probably going to have to leave before two witnesses from Illinois, George O'Neill and Dr. Terry Mason, testify, and I simply want to apologize to them and express my appreciation for their being here.

Dr. Raum, you mentioned that your insurance went from $2,000 to $50,000; is that correct?

Dr. **Raum**. Yes.

Senator **Simon**. How much coverage on the $2,000 and $50,000, did you have?

Dr. **Raum**. I had $1 million per occurrence, and $3 million total for the year. The plan I have—you would expect some increase. Over the first 6 years, there would be automatic increases, but over and above that were these very, very large increases.

Senator **Simon**. How much coverage on that first $2,000 policy did you have?

Dr. **Raum**. $1 million and $3 million.

Senator **Simon**. How much do you now have?

Dr. **Raum**. $500,000. Actually, I have just dropped it now, again, to send in the notice, because even then, it was still $31,000 for $500,000 worth of coverage.

Senator **Simon**. When we discuss this problem—and it is a very severe problem, as the four of you have illustrated—with trial lawyers, they blame the medical profession; when we talk to representatives of the Medical Association, they blame the trial lawyers and the tort system. I tend to believe that maybe they are both a little bit right.

One question I have had which physicians tell me is a very difficult question to deal with, is the question of alcoholism within the ranks.

You were asked by Senator Kennedy do you know physicians who are in a situation where they are not practicing as they should, and your response came back largely negative——

Dr. **Raum**. I am sorry. I thought he specifically meant obstetric practice.

Senator **Simon**. I am willing to expand that question and ask: Do you know of physicians within your ranks who have serious alcohol problems, and how do you deal with that, and how can we deal with that as a society?

Dr. **Raum**. There is an impaired physician division within the Florida Medical Association. Our own county medical society has a committee of physicians, some of whom are recovered alcoholics themselves and very much recognize the problem, and who will go to a physician who is suspected of having this problem and address it. And we are recognizing it and trying to rectify it. You cannot discover this overnight, and you cannot rectify it overnight. But we are not trying to ignore the problem. We are directly addressing it on a 1-to-1 basis as it becomes—if there is a complaint lodged, that committee will go and see that person and address them about it and see that they get care.

Senator **Simon**. Let us just say—usually, you know, somebody does not come up to you and say, "I am an alcoholic." You hear a rumor about Dr. Smith or Dr. Jones. How do you handle that now, personally? I do not mean to put you on the spot, Dr. Raum.

Dr. **Raum**. First of all, if it was somebody I definitely had had patients tell me things, then I would take it to the physicians who are on that complaint committee. And I think they have been, in our particular county, responsive to this. Certainly, I would not refer patients to them if I thought that that was a problem.

And you are absolutely right, we have to address it from our end, also, and be willing to confront these problems. There is now in Florida an automatic review by the department of professional regulation, and I cannot tell you if it is for more than two suits or more than three suits that are found against a physician, but that is now in place. It has not been in place long, but it will automatically bring these people up before professional regulatory committees if they have a certain number of suits brought.

Senator **Simon**. Thank you.

Do the other three of you wish to make any comments on this problem?

Dr. McQuarrie—incidentally, I am impressed by your leadership and your forthrightness. I really appreciate it.

Dr. **McQuarrie**. Your questions are in the area of management of the impaired physicians. We physicians have no more of an impairment problem than any other industry. It is sensitive because of the sensitivity of the issue today.

The style of managing by our Impaired Physician Committees is confrontation and getting them into a rehabilitation program. We try to keep them out of the regulatory status. But interestingly enough, as I tried to explain in my testimony, these are not the physicians that are at the brunt of our malpractice crunch. It is our technically excellent physicians who are on the cutting edge of medical advancement who are most vulnerable, and that is because the outcomes are so severe if the outcomes are unfavorable.

Senator **Simon**. Dr. Rydland or Dr. Gaddy, do you wish to add anything.

Dr. **Rydland**. I really do not think I have anything to add to Dr. McQuarrie's testimony.

Dr. **Gaddy**. We, in South Carolina, have an Impaired Physicians Committee also, and we also have a recent regulation that has been passed that any physician that has a change in his status on hospital staff for disciplinary reasons has to be reported to the Board of Medical Examiners.

I think there is also a move afoot to have some cross-communication between neighboring States and also the other States of the Union to try to get information concerning physicians that have had malpractice suits filed against them or any disciplinary actions, also.

Senator **Simon**. Thank you.

One other question, Dr. Rydland. You mentioned the Cumberland, MD situation as it relates to the two States. Is the differentiation in pay on Medicaid a major problem. I know we are moving away from the malpractice insurance problem, but this is an important issue. Is the difference that Maryland pays and West Virginia pays a substantial problem in the practice of medicine in your area?

Dr. RYDLAND. Well, I think that is the reason that the physicians in Cumberland no longer accept West Virginia Medicaid patients. The patients that I am taking that they have turned down, they have turned down in the middle of their pregnancies or have refused to take as soon as they find out that they are pregnant.

Most of these patients geographically live closer to Cumberland than they do to Petersburg, but cannot get care in Cumberland, which is 20 or 25 minutes away, and instead have to travel an hour to come and see me.

Senator SIMON. How much difference is there between what Maryland pays and West Virginia pays? Is it substantial?

Dr. RYDLAND. I do not have the figure on what Maryland pays for obstetrical care. In West Virginia, the reimbursement for care, including all of the antipartum care, delivery, and all of the postpartum care, is $255. And as you have heard today, in most States, those fees are running right around $1,200 to $1,400.

I know the physicians in Cumberland have had their malpractice go up, and they do not feel that that is adequate reimbursement to cover the malpractice that they have to pay to take care of those patients.

But I do not know what they pay in Maryland.

Senator SIMON. I thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Simon.

I want to thank you all. This has been a particularly good panel; you have been very helpful to us.

And Dr. McQuarrie, from my own State, a man I have a lot of respect for, as I do all of you, I hope you will give us as much help as you can on this. We really want the expert help. This is a very difficult set of problems, and the bill is filed basically to create commentary and create debate and to get all of the parties working together so we can come up with a consensus approach that might solve these problems.

So we are grateful to have all of you here, and we appreciate the efforts you have put forth to be with us.

Thank you so much.

Our third panel will discuss dislocation problems caused by the malpractice crisis in fields other than obstetrics and gynecology.

Our panelists are: Dr. Gaston Acosta-Rua, a neurosurgeon from Jacksonville, FL, who is the president-elect of the Florida Neurosurgical Society; Dr. Barbara Rockett, a general surgeon from Boston, who is president of the Massachusetts Medical Society; Dr. Terry Mason, a urologist from Chicago who is president of the Cooke County Physicians Association, and Mr. George O'Neill, executive director of the Shawnee Health Service and Development Corp.

So if you will all come to the table, we will begin with you, Dr. Acosta-Rua, and go from there. Now, again, if you can summarize in less than 5 minutes, I would appreciate it, but I will cut you off at 5 minutes. This hearing is going to be a lot longer than I had planned on my schedule, so what I am going to have to do is stay as long as I can—all of the testimony is important—and then have Counsel for the Full Labor Committee continue the hearing until we finish every witness here today.

So, Dr. Acosta-Rua, we will turn to you. Thank you for being here.

We welcome all of you. We appreciate the efforts you have put forward, and we really look forward to hearing your testimony.

STATEMENT OF GASTON J. ACOSTA-RUA, M.D., FELLOW, AMERICAN COLLEGE OF SURGEONS, JACKSONVILLE, FL; BARBARA A. ROCKETT, M.D., GENERAL SURGEON, BOSTON, MA; TERRY MASON, M.D., UROLOGIST, CHICAGO, IL; AND GEORGE O'NEILL, JR., EXECUTIVE DIRECTOR, SHAWNEE HEALTH SERVICE & DEVELOPMENT CORP., MURPHYSBORO, IL

Dr. ACOSTA-RUA. My name is Gaston Acosta-Rua, and I am a physician specializing in neurosurgery in Florida, in the city of Jacksonville, since 1972.

Over the last few years, we have experienced a great change in the care and treatment of neurosurgical patients in the State of Florida. Because more than 95 percent of neurosurgeons in Florida have been sued at least once, we have been forced to practice a very different type of medicine than we used to.

Although trial lawyers are fond of saying that the liability crisis is created by bad physicians, it is hard to believe that 95 percent of well-trained, highly qualified neurosurgeons in Florida are incompetent.

The high risk of being sued and the excessive insurance premiums that neurosurgeons are paying in Florida have forced many excellent physicians to an early retirement, to limit their practice to medical treatment only, or to move out of the State.

This same situation has also kept many young, brilliant neurosurgeons from coming to Florida and thus maintaining the state of the art up to date.

In order to demonstrate my point of view, I am going to give some specific examples.

Dr. Leonard Mallis, one of the leading neurosurgeons in the United States, who has made major contributions in the field of neurosurgery, has stated tbat patients with arteriovenous malformations of the spinal cord should not be treated in this country because of the high risk of legal implications.

The best medicine in any place in the history of mankind has been and still is being practiced in our country. It is therefore deplorable that our citizens must be sent away to receive the same or lesser treatment.

In my community the neurosurgical manpower has diminished by 25 percent in the last year, and in other cities by 40 to 50 percent. This is due to early retirement of some neurosurgeons and others by moving out of the State.

As far as attracting new neurosurgeons to our community, I can give the example of my own experience. Because of the early retirement of two of our associates, we have been actively seeking to recruit one or two members. A very well-trained young neurosurgeon, a native of Jacksonville and the son of a local physician who was interested in returning to his home town, elected to establish his practice in a different State because of the liability crisis in Florida.

Furthermore, because of the reduction of our group, we have had to limit our emergency coverage from six hospitals to only four. Some of our colleagues in other areas of central Florida, not being so fortunate to be able to limit their practice, are being forced to be on call for 7 days a week around the year.

It is, of course, unrealistic to expect that any doctor can fulfill such a demanding responsibility for an extended period of time.

As a compassionate human being, I am also extremely concerned by the effect that the professional liability crisis is having on the once sacred doctor/patient relationship.

For example, I can no longer put my hand over the shoulders of a grieving parent, on whose child I am about to operate and give him comforting words, because that might be misinterpreted as a warranty of a successful result. Consequently, instead of compassionate, I may come across as blunt and uncaring, while I am only trying to protect myself.

I would like to explain the devastating experience of a doctor during a malpractice suit. It can be compared to the effects of a bitter divorce. In both situations, a long-term, stable bond has been broken, thus greatly affecting the partners as well as the future ones. A mutually trusting relationship has been destroyed.

I was sued once, and fortunately, I won the case. It is ironic that sometime later, one of the plaintiff's attorneys called on me to treat his very sick father. Of course, I complied, and fortunately, the patient is doing well now. However, the question in my mind remains: How come a man who earlier was questioning my competence as a neurosurgeon was later entrusting to me his father's life? Is the problem of the professional liability crisis due to poor-quality doctors?

And last but not least of the problems, I want to mention the financial implications of the liability crisis. I would like to conclude by saying that should the day come when we, Florida neurosurgeons, could no longer afford to pay our insurance premiums, we will either decide to quit our surgical practice, or to move to another State. This will, of course, be a tremendous loss of talent and investment for the community.

I want to thank you for the opportunity.

[The prepared statement of Dr. Acosta-Rua and response to the question submitted by the chairman follow:]

Testimony of

DR. ACOSTA-RUA

Before the

COMMITTEE ON LABOR AND HUMAN RESOURCES

May 7, 1986

Dr. Acosta-Rua

Labor and Human Resources Committee
United States Senate

Dear Sirs:

My name is Gaston J. Acosta-Rua. I am a physician specializing in neurosurgery. I have been in private practice in Jacksonville, FL since 1972. I am a member of the Lyerly Neurosurgical Group of which I am presently the senior partner. The Lyerly Neurosurgical Group is the oldest group of neurosurgeons in the Southeastern United States and was founded by the oldest living neurosurgeon in the country. The reputation of our group is well known, not only in the state of Florida but in many other states as well as abroad.

I am a Cuban-American, graduate of the University of Madrid, Spain Medical School, and I have trained at CASE Western Reserve University in Ohio and as a neurosurgeon at the University of Iowa and the University Hospital in Zurich, Switzerland.

I am a Board certified neurosurgeon, a Fellow of the American College of Surgeons, the President-Elect of the Florida Neurosurgical Society, and the Vice President of my County medical society. I am also an active member of many civic societies in my community such as the Chamber of Commerce and the Meninak Club.

I have had the honor of being invited to testify on this Committee in regard to the Professional Liability crisis in the state of Florida in reference to neurosurgery.

Over the last few years we have experienced a great change in the care and treatment of neurosurgical patients in the state of Florida. Because more than 95% of the neurosurgeons in Florida have been sued at least once, we have been forced to practice a very different type of medicine than we use to. Although trial lawyers are fond of saying that the Liability Crisis is created by bad physicians, it is hard to believe that 95% of well trained, highly qualified neurosurgeons in Florida are incompetent.

The high risk of being sued and the excessive insurance premiums that neurosurgeons are paying in Florida, have forced many excellent physicians to an early retirement, to limit their practice to medical treatment only, or to move out of the state. This same situation has also kept many young, brilliant neurosurgeons from coming to Florida and thus, maintaining the state-of-the-art up to date. In order to demonstrate my point of view I will give some specific examples.

Among five members of the staff of one of the medical schools in Florida, eleven million dollars have been awarded in malpractice suits.

The Professor and Chairman of another medical school is no longer performing surgery because of similar reasons. How can we accept that the professors who teach our future neurosurgeons are incomptent?

Dr. Leonard Mallis, one of the leading neurosurgeons in the United States, who has made major contributions to the field of neurosurgery has stated that patients with arteriovenous malformations of the spinal cord should not be treated in this Country because of the high risk of legal implications.

The best medicine in any place in the history of mankind has been, and still is, being practiced in our Country. It is, therefore, deplorable that our citizens must be sent away to receive the same or lesser treatment than in the United States because of our increasing concern with being sued.

In my community the neurosurgical manpower has diminished by 25% in the last year and in other cities by 40-50%, because of early retirements and moves of neurosurgeons out of the State. This is of course due to the above mentioned Liability Crisis.

As far as attracting new neurosurgeons to our community I can give the example of my own experience. Because of the early retirement of two of our associates, we have been actively seeking to recruit one or two new members. A very well trained young neurosurgeon, native of Jacksonville and the son of a local physician who was interested in returning to his home town, elected to establish his practice in a different state because of the Liability Crisis in Florida.

Furthermore, due to the shrinkage of our group, we have had to limit our emergency coverage from six hospitals to only four.

Some of our colleagues in other areas of central Florida, (namely in Cocoa Beach and Ocala), not being so fortunate to be able to limit their practices, are being forced to be on call seven days a week around the year. It is, of course, unrealistic to expect that any doctor can fulfill such a demanding responsibility for an extended period of time.

As a compassionate human being I am also extremely concerned by the effect that the Professional Liability Crisis is having on the, once sacred, doctor/patient relationship.

For example, I can no longer put my hand over the shoulders of a grieving parent, on whose child I am about to operate and give him comforting words, because that might be misinterpreted as a waranty of a successful result. Consequently, instead of compassionate, I may come across as blunt and uncaring, while I am only trying to protect myself.

This kind of approach is very much against my idea of what a physician should be.

I would like to explain the devastating experience of a doctor enduring a malpractice suit. It can be compared to the effects of a bitter divorce. In both situations, along term, stable bond has been broken, thus greatly affecting the partners as well as the future ones. A mutually trusting relationship has been destroyed.

I would like to share with you mine and others' experiences with a malpractice suit.

Several years ago I saw a patient from a nearby community whom I diagnosed as having an arteriovenous malformation of the brain. Because of the size and the location of the malformation, it was inoperable. The patient was suffering from severe headaches and, as it was well described by her neurologist and herself, she had a "time bomb ticking in her head ready to explode." The only possible available treatment was an embolization of the malformation. At that time, I was the only neurosurgeon with the required training and experience who had performed this procedure in my community. Through the surgery, the malformation was reduced by 80%, her life was saved and her severe headaches disappeared. However, she developed a stroke with partial impairment of her left arm and leg. This patient sued me for three million dollars. The plaintiff's attorney wanted to settle the case for $1.5 million dollars which was the limits of my insurance coverage. This was refused. A few days before the trial, my company lawyer received a threatening letter, with a copy addressed to me, stating that should we lose the case and the jury award should be above the limits of my insurance coverage, they will come for my personal assets. Unfortunately, in some cases in Florida this has occured, forcing the physician to file for bankruptcy.

Fortunately I won the suit. This meant one and a half years of anguish "pain and suffering" for me, my family, my friends, and my patients. That also included a lot of trips aroung the Country assisting my lawyer in taking depositions and one full week on court trial.

The state of Florida law clearly states that the losing party of a suit is responsible for all of the court expenses. However, that was not so in my case. I was advised by my attorney to relinquish such rights because the plaintiff's attorney had made the deal that, by doing so, they would withdraw their appeal. In any case, should I pursue that route, the patient would declare herself in bankruptcy and she will not pay anyway.

It was a nice 1981 Christmas present but it could hardly be considered a success story.

It is ironic that sometime later, one of the plaintiff's attorneys called on me to treat his very sick father. Of course, I complied and fortunately, the patient is doing well now. However, the question in my mind remains. How come a man who earlier was questioning my competence as a neurosurgeon was later entrusting to me his father's life? Is the problem of the professional liability crisis due to poor quality doctors?

As an example of a frivolous suit, I will mention the following case. A 75 year old man was operated for a brain tumor by an Ocala neurosurgeon. The outcome was good and the patient had no neurological deficit after the operation. However, later on an infection occurred and the surgeon recommended a second operation. After consistently refusing the advised surgery, the patient finally went to Miami where he underwent the originally recommended procedure. He then decided to move to England. His 72 year old wife, who remained in the United States and her lawyer sued the Ocala neurosurgeon for two-hundred Thousand dollars for "loss of consortion" due to a delay of the second operation.

The insurance company, without the surgeon's consent and without regard for the surgeon's reputation, decided to settle the case for twenty-thousand dollars to avoid further troubles and costs. Of course, the neurosurgeon, who had no say in this decision, had his reputation forever damaged and his attitude forever changed.

And last, but not least of the problems I want to mention, the financial implications of the liability crisis.

"Money is not the real problem."

I have learned that from my own patients. When a patient or a relative comes to me saying, "doctor, do what you must because money is not the problem", it usually means that they are not going to pay anyway therefore, "money is not the problem."

We, the neurosurgeons, can say the same thing. In spite of the fast rising insurance premiums (between $71,000 and $120,000 in 1986), money is not the problem because WE are not going to pay it. The consumers from Florida, through higher medical fees, will be the ultimate ones to pay. This could be hardly considered a way of reducing medical costs in Florida.

Should the day come when we, Florida neurosurgeons, could no longer afford to pay our insurance premiums, we will either decide to quit our surgical practice or to move to another state. This will, of course, be a tremendous loss of talent and investment for the community.

As a possible solution for this critical problem, the Florida Medical Association has endorsed capitation for pain and suffering awards; a limitation for contingency fees for lawyers and a specification of the law in regards to joint and several liability.

I, as a neurosurgeon, can foresee that these bills, if passed, may alleviate the economical crisis and will be a step in the right direction. However, they will not solve completely the basic problem.

I have contacted many of the leading neurosurgeons of the State and all of us agree that the institution of a mediation panel will eliminate most of the frivolous and fraudulent malpractice suits without interfering with the meritorious ones.

Such a mediation panel, composed of a physician, a lawyer, and an unrelated lay person, could make intelligent determinations of the merits of a law suit. Should a case be considered meritory, it could then be recommended for either a reasonable settlement or for a trial by jury.

I want to close my remarks by appreciating the opportunity to express my feelings and opinions in front of such an eminent group of U.S. Senators. This is a particularly great honor for me who, only 25 years ago, came to this Land of Liberty as a political refugee.

Given the opportunity I have put all of my strength and efforts to work for our Country and our Profession, as well as to earn the respect of my fellow Americans.

Respectfully submitted,

Gaston J. Acosta-Rua, M.D., F.A.C.S.

QUESTIONS FOR DR. ACOSTA-RUA

1. DR. ACOSTA-RUA, HOW SERIOUS A LONG-TERM EFFECT WILL THE MALPRACTICE INSURANCE CRISIS HAVE ON THE AVAILABILITY OF NEUROSURGEONS IN THIS COUNTRY IF THE CRISIS GOES ON UNABATED?

A. In my opinion, the Professional Liability Crisis will affect the future of neurosurgery in two main ways. On one hand, it would certainly discourage young physicians from entering the most risky specialties, such as neurosurgery.

On the other hand, the existing neurosurgeons will continue to limit their practice to the less dangerous procedures, to protect themselves from potential malpractice suits. By at least these two ways the availability of neurosurgical services will most likely be curtailed.

The CHAIRMAN. Thank you so much, Doctor.

Dr. Rockett, we will hear from you now.

Dr. ROCKETT. Thank you, Mr Chairman and members of the committee for the opportunity to appear before you to describe the Massachusetts experience with medical malpractice insurance.

I am Dr. Barbara Rockett, president of the Massachusetts Medical Society. I represent 13,530 physicians, and my husband is a neurosurgeon, and we have 2 sons anticipating entering the practice of medicine.

The CHAIRMAN. So you really have a stake in this.

Dr. ROCKETT. I certainly do.

There is little question that the problem of liability insurance is affecting all of our lives. We, in Massachusetts, are in the midst of a crisis driven by tremendous increases in the cost of medical malpractice insurance. In 1982, physicians in high-risk specialties, such as neurosurgery and orthopedic surgery, paid $11,200 for malpractice insurance issued by the Massachusetts Joint Underwriting Association.

In 1984, the price of insurance for those specialists increased to $15,300. In December 1985, the rates spiraled to $26,900. Just last week, a request was made to raise rates to $56,600. Within the next several weeks, we expect a further rate increase. If approved, rates would be $60,400 per year.

To make matters worse, these rate increases are retroactive in effect, going back as far as 1983. Our highest risk groups could face payments of $121,600 in 1986, due to surges in premiums and retroactive payments.

Physicians in Massachusetts practice in a highly regulated environment where fees are rigidly controlled under a series of State laws. Yet there are no controls on costs, and the cost of malpractice insurance has risen to levels that are unaffordable.

We have always taken pride in the quality of our medical care in Massachusetts. Our tradition of high-quality care, however, is being seriously eroded by the liability crisis. If the liability crisis continues, health care will suffer, and that is our greatest concern.

That concern led the Massachusetts Medical Society to conduct an informal survey of its members. The survey was made after the approval of the last round of rate increases, but before the latest rate request. One out of every six physicians reported a significant change in his practice due to insurance premium increases. These physicians told us that they were no longer undertaking high-risk procedures, or were retiring prematurely, or were even leaving Massachusetts.

Forty-seven percent of the 2,600 physicians responding to our survey reported that they were actively considering those same options. In the face of staggering premium increases, many physicians dropped obstetrics and orthopedic surgery. By excluding high-risk procedures, they could drastically reduce their insurance costs—and, I might add, their liability costs as well.

Of the approximately 600 obstetricians in Massachusetts, 159 obstetricians insured by the JUA responded to our survey. Forty-five percent of the obstetricians indicated that increases in malpractice insurance had caused them to change their practice, primarily by not taking any new obstetrical patients.

Forty-nine percent of those responding reported that they were actively considering a similar move. Only 9 percent said that they were unaffected by increases in the cost of insurance. The results for orthopedic surgeons were similar.

As previously mentioned, rate increases were announced in December of last year. By the beginning of February of this year, patients throughout Metropolitan Boston were experiencing difficulty in obtaining care. Expectant mothers were unable to see obstetricians in their communities. Elective surgery in orthopedics was canceled, and, in some cases, trauma victims had to be transferred to Boston teaching hospitals after being stabilized at suburban hospitals, because of a lack of orthopedic surgeons.

The leadership of our State legislature called on physicians to resume their specialty practice, assuring them that the malpractice crisis would be resolved by this April. Threats of litigation were made at this point by our State attorney general.

By mid-March, many physicians resumed their specialty practice and the situation stabilized. Some physicians did not return to practice, however, and the loss of these physicians continues to be felt by their former patients.

There is every reason to fear that we will experience a far greater crisis in the coming months. We did not see a legislative solution emerge during the month of April. A comprehensive malpractice bill is making its way through our legislature, but it is unclear whether the final product will bring relief.

In the meantime, the Massachusetts Joint Underwriting Association has just requested another retroactive increase of 99 percent.

Physicians in Massachusetts are being squeezed out of practice by the combination of skyrocketing malpractice costs and limits on the fees that they are paid.

At the hospital where I practice, we had, as of January 1, 13 obstetricians. We are now down to six obstetricians, and I am told that three more are anticipating leaving.

To physicians in Massachusetts, the options before our State legislature are clear. Either we change tort law to make it more reasonable and efficient, and thereby control the cost of the liability system, or we allow the current system to continue on its present course, and watch the destruction of health care in our State.

The results of recent public opinion surveys demonstrate deep public concern over the malpractice insurance crisis and strong support for tort reform as a means of resolving the crisis.

A public opinion poll conducted on behalf of the Massachusetts Medical Society indicated that nearly 73 percent of the residents of our State believe that the malpractice insurance crisis, if left unchecked, could reduce the quality of health care.

The CHAIRMAN. Dr. Rockett, we are going to interrupt you at this point and put the rest of your statement in the record.

We appreciate the statement; it has been very good.

Dr. ROCKETT. Thank you.

[The prepared statement of Dr. Rockett follows:]

MASSACHUSETTS MEDICAL SOCIETY
1440 Main Street, Waltham, Massachusetts 02254 (617) 893-4610 WATS 1-800-322-2303

7 May 1986

STATEMENT OF BARBARA A. ROCKETT, M.D.
PRESIDENT, MASSACHUSETTS MEDICAL SOCIETY

Thank you Mr. Chairman and members of the Committee for the opportunity to appear before you to describe the Massachusetts experience with medical malpractice insurance. There is little question that the problem of liability insurance is affecting all of our lives.

We in Massachusetts are in the midst of a crisis driven by tremendous increases in the cost of medical malpractice insurance. In 1982, physicians in high risk specialties such as neurosurgery and orthopedic surgery paid $11,200 for malpractice insurance issued by the Massachusetts Joint Underwriting Association.

In 1984 the price of insurance for those specialists increased to $15,300. In December of 1985 the rates spiraled to $26,900. Just last week a request was made to raise rates to $56,600. Within the next several weeks, we expect a further rate request. If approved, rates would be $60,400 per year.

To make matters worse, these rate increases are retroactive in effect, going back as far as 1983. Our highest risk groups could face payments of $121,600 in 1986, due to surges in premiums and retroactive payments.

Physicians in Massachusetts practice in a highly regulated environment where fees are rigidly controlled under a series of state laws. Yet there are no controls on costs, and the cost of malpractice insurance has risen to levels that are unaffordable.

We have always taken pride in the quality of our medical care in Massachusetts. Our tradition of high quality care, however, is being seriously eroded by the liability crisis. If the liability crisis continues, health care will suffer, and that is our greatest concern.

That concern lead the Massachusetts Medical Society to conduct an informal survey of its members. The survey was made after the approval of the last round of rate increases but before the latest rate request. One out of every six physicians reported a significant change in his practice due to insurance premium increases. These physicians told us that they were no longer undertaking high risk procedures, or were retiring prematurely, or were leaving Massachusetts.

Forty-seven percent of the twenty-six hundred physicians responding to our survey reported that they were actively considering those same options.

In the face of staggering premium increases, many physicians dropped obstetrics and orthopedic surgery. By excluding high risk procedures, they could drastically reduce their insurance costs.

Of the approximately six hundred obstetricians in Massachusetts, one hundred fifty-nine obstetricians insured by the Joint Underwriting Association responded to our survey. Forty-five percent of the obstetricians indicated that increases in malpractice insurance had caused them to change their practice, primarily by not taking any new obstetrical patients. Forty-nine percent of those responding reported that they were actively considering a similar move. Only nine percent said that they were unaffected by increases in the cost of insurance. The results for orthopedic surgeons were similar.

As previously mentioned, rate increases were announced in December of last year. By the beginning of February of this year, patients throughout Metropolitan Boston were experiencing difficulty in obtaining care. Expectant mothers were unable to see obstetricians in their communities. Elective orthopedic surgery was cancelled, and in some cases trauma victims had to be transferred to Boston teaching hospitals after being stabilized at suburban hospitals because of a lack of orthopedic surgeons.

The leadership of our state legislature called on physicians to resume their specialty practice, assuring them that the malpractice crisis would be resolved by this April. Threats of litigation were made by our Attorney General.

By mid-March, many physicians resumed their specialty practice and the situation stabilized. Some physicians did not return to practice, however, and the loss of these physicians continues to be felt by their former patients.

There is every reason to fear that we will experience a far greater crisis in the coming months. We did not see a legislative solution emerge during the month of April. A comprehensive malpractice bill is making its way through our legislature, but it is unclear whether the final product will bring relief. In the meantime, our Joint Underwriting Association has just requested another retroactive increase, averaging ninety-nine percent.

Physicians in Massachusetts are being squeezed out of practice by the combination of skyrocketing malpractice costs and limits on the fees that they are paid.

At the hospital where I practice, there were thirteen obstetricians on the staff on January 1, 1986. As of November 1, 1986 we expect that we will have only six obstetricians at our hospital. We cannot suffer these kinds of losses without a serious adverse effect on patient care.

To physicians in Massachusetts, the options before our legislature are clear. Either we change tort law to make it more reasonable and efficient, and thereby control the cost of the liability system, or we allow the current system to continue its present course, and watch the destruction of health care in our state.

The results of recent public opinion surveys demonstrate deep public concern over the malpractice insurance crisis and strong support for tort reform as a means of resolving the crisis. A public opinion poll conducted on behalf of the Massachusetts Medical Society indicated that nearly seventy-three percent of the residents of our state believe that the malpractice insurance crisis, if left unchecked, could reduce the quality of health care.

This same survey indicated nearly eighty percent of the people of Massachusetts would support legislation imposing limits on awards and on attorneys' contingent fees as a means of alleviating the crisis. This is but one of several public opinion surveys recently conducted in Massachusetts on this issue, but the results have been consistent through all the surveys.

The liability crisis must be confronted and resolved, not just for physicians in Massachusetts, but for the sake of all. Thank you again for the opportunity to appear before you to voice our concerns.

/az

The CHAIRMAN. Dr. Mason.

Dr. MASON. My name is Terry Mason, and I am a physician on the south side of Chicago, specializing in neurology.

My office is on 32d and King Drive and affiliated with three hospitals, one of them being Providence Hospital, the first independent black hospital, founded in 1891.

I would like to thank Senator Hatch for inviting me to testify in front of this very distinguished panel.

I am a life-long resident of the city of Chicago. I grew up in an Englewood neighborhood. It was then and is still an area of poverty and hopelessness. I attended Chicago public high schools from kindergarten through high school; and I attended Loyola University in Chicago, undergraduate school, and the University of Illinois in Chicago for medical school. I completed a 2-year residency in general surgery at Mercy Hospital in Chicago and a residency in neurology at Michael Reese, also in Chicago.

I am a product of what some of the activities were in the 1960's, and I guess I owe a debt of gratitude to your colleagues for making it possible in the 1960's for opening up through the Health Professions Loan Act and some of the other things, making it possible for me and, I suppose 150 other colleagues like myself, to get through medical school.

I am in the third term as president of the Cook County Physicians Association, which is the local chapter of the National Medical Asssociation. I am on the executive board of the south side branch of the NAACP, and on the Governmental Affairs Committee of the Illinois State Medical Society. I also sit on various committees, councils, and other community organizations that used to interest young people in going into health careers.

I am sorry to say that I no longer encourage any youth at this point to go into medicine. I discourage them all from practicing, particularly in my specialty, obstetrics and gynecology, and orthopedic surgery.

I tell all the residents that are coming out of the University of Illinois, Loyola, Northwestern, and the other three medical schools in the Chicago area that they should probably reconsider their opportunities in Cook County.

If I could find a better malpractice climate, and I have considered that, I would move.

Already, as of July of this year, I am considering dropping all of pediatric practice from my current urologic practice because of the potential for litigation for 18 years as a child and then statute of limitation-invoking for 4 years.

The litigation crisis at this point continues to threaten to reverse all the gains made over the last 2 decades in providing quality health care for the inner-city resident. We practice in an area where many of the patients are on public aid or Medicare, and our reimbursement levels from the State as well as the frozen fees from Medicare, make it impossible for us to pass on these tremendous increases in malpractice insurance premiums along to our patients.

We need reforms which would reduce the abuses of the legal system, but preserve the right of malpractice victims to fully recover their economic losses due to injury. If States have assistance and leadership from the Federal Government, much like the bill that you are sponsoring, physicians and others in the health care field will continue to provide good care for inner-city residents.

This access is threatened because physicians cannot pay ever-increasing malpractice premiums from a practice income which continues to be limited.

The fastest-rising practice expense that I have, as well as most of the other physicians that practice in the city of Chicago, is malpractice insurance. And it is most costly in areas where litigation is more frequent, and where jury awards and settlements tend to be higher than less urban areas.

My own insurance premium went from $8,000 in 1983 when I started practice—and I have taken over a practice from a urologist who has been in the community for 30 years and is retiring at age 82 now—and this is a practice that I have looked forward to since I began my training—but my practice started in July 1983, and I paid $8,000 through a discounted arrangement with the State Medical Society's Insurance Program. Now, that premium is over $24,000. And I do not know what it is going to become July 1.

I do know that because of the malpractice problems that the form of the insurance has changed, and this has weighed heavily in my decision to drop pediatrics from my practice.

You probably have little sympathy for the premiums I pay. You should have sympathy for those patients who will not be able to get care easily because physicians have left the inner city, or never come there in the first place.

Imagine a young minority physician like myself going through the costly business of establishing a practice after leaving a long, grueling and expensive medical school residency, probably $50,000 to $125,000 in debt; imagine what it would be like trying to get on your feet financially while facing the prospect of practice expenses exceeding practice income.

What I would like to say in closing is that I would not be here if you had not worked right alongside me in the struggle for equal opportunity in America. I am a product of the equal opportunity dream. I am a minority physician of impoverished parents who was not supposed to break the cycle of poverty and who did. I overcame many obstacles with your help, but this is one obstacle that I may not be able to overcome. It it out of my control.

If it was a medical problem, I could solve it; but this seems to be a legal one, and it is in your hands.

Thank you.

The CHAIRMAN. Thank you, Dr. Mason. We are very proud of you and what you have been able to accomplish, and we are sorry you are having these kinds of problems.

[The prepared statement of Dr. Mason follows:]

TESTIMONY

TERRY MASON, M.D.

PRESIDENT, COOK COUNTY (ILLINOIS) PHYSICIANS ASSOCIATION

BEFORE THE SENATE COMMITTEE ON LABOR & HUMAN RESOURCES

WEDNESDAY, MAY 7, 1986, WASHINGTON D.C.

My name is Terry Mason. I am a physician on Chicago's South South specializing in urology. My office is located at 32nd and Martin Luther King Drive. I am affiliated with three hospitals: Mercy, Hyde Park Community and Provident Hospital, the first independent black hospital in the country, founded in 1891.

I very much appreciate the opportunity to present to you a personal viewpoint about what it's like to care for inner city patients in the current malpractice crisis.

I am a lifelong resident of Chicago and its inner city. I grew up in the Englewood neighborhood. It was then and is still an area of poverty and hopelessness. I attended Chicago Vocational High School and ventured for the first and only time to Chicago's North Side to attend Loyola University. I graduated from the University of Illinois Medical School in 1978. Following that, I completed a two year general surgery residency at Mercy Hospital and another residency in urology at Michael Reese Hospital.

In addition to my medical practice. I am an assistant professor of surgery at the University of Illinois in the section of urology. I am in my third term as president of the Cook County Physicians Association, the 150 member local chapter of the National Medical Association, an organization for black physicians. I'm on the Executive Board of the South Side Branch of the National Association for the Advancement of Colored People and am a member of the Governmental Affairs Committee of the Illinois State Medical Society. I serve on various committees to try to interest young people in health careers.

I no longer encourage them to be physicians and if they are, I discourage them from practicing my specialty or any other high-risk specialty. I tell residents looking for a practice location not to practice in Cook County. If I could do something else for a living, I would quit practice. If I could find a better malpractice climate, I would move. If I could go back to Englewood and practice, without the constant pressure of potential malpractice suits, that is what I would wish to do.

The litigation crisis threatens to reverse the gains made over the last two decades in providing quality health care for the inner city resident. You have worked hard to guarantee that there is not one standard of care for the well-to-do, and another for the less fortunate. This is under seige by a legal system that is out of control. Once again, federal leadership is needed to break down a barrier to good health care that faces the inner city poor. Reforms are needed which will reduce the abuses of the legal system, but which preserve the right of malpractice victims to fully recover their economic losses due to the injury. If states have assistance and leadership from the federal government to enact these reforms, physicians and others in the health care field will continue to provide care to the urban poor.

Access to care is threatened because physicians cannot pay ever-increasing malpractice premiums from a practice income limited by federal, state and commercial carriers' shrinking reimbursement levels. The federal government has frozen my fees; the state government reimburses at less than cost. But, my malpractice premium is increasing and due every quarter. And, because my patients are the urban poor, I cannot pass along these costs.

The fastest rising practice expense is malpractice insurance. This insurance is most costly in urban areas where litigation is more frequent, and where jury awards and settlements tend to be higher than in less urban areas. My own insurance premium is now $23,000, 65% higher than the premium for physicians in the same specialty in less urban areas of Illinois. Premiums are expected to rise each year. In the last three years alone, premiums have increased 90%.

You probably have little sympathy for the premiums I pay. You should have sympathy for those patients who won't be able to get care easily because physicians have left the inner city, or never come there in the first place. Imagine a young minority physician like myself going through the costly business of establishing a practice after leaving a long, grueling and expensive medical school and residency, probably $50,000 to $100,000 dollars in debt. Imagine what it would be like to try to get on your feet financially while facing the prospect of practice expenses exceeding practice income. For this reason, good doctors are leaving the inner city.

What we are seeing is the spectre of the inner city, already medically underserved, facing even less access to care due to the economic inability of medical professionals to provide their services.

The reasons malpractice insurance costs are high can be blamed on frivolous suits and excessive jury awards.

Five out of 10 Illinois doctors are sued each year. But, 80% of the suits are resolved with no fault found with the physicians.

Jury awards have risen 143% from an average of $420,000 in 1978 when I began practice to over $1 million in 1984.

The costs of malpractice go beyond the financial. They take their toll in physicians not choosing a high-risk specialty, and in young, talented dedicated people not choosing medicine at all. They take their toll when physicians like me choose to practice in a more favorable malpractice climate, and abandon the poor I care about and would like to care for. Malpractice takes its toll when a highly skilled, middle aged physician gives up practice and retires years before he or she should. And malpractice takes an emotional toll.

A lawsuit attacks my integrity. Repeated assaults, even though unfounded, take a psychological toll on the physician. It saps energy, dedication and takes away from the attention I should pay to the patient.

Tell me how I can think first, foremost and only of my patient without having also to think of protecting myself against a lawsuit. I can deal with the pressures of having to make decisions on how to save lives. But I shouldn't have to deal at the same time with the anxiety of how my actions are going to look on the record.

The South Side of Chicago needs more doctors, not less. If there is a national surplus of doctors, this is indeed news to my community. South Side neighborhoods are consistently pinpointed by the federal government as not having enough physicians for the population. It's not just the South Side but it's also the West Side and certain areas of the North Side. And, it's not just Cook County and the city of Chicago but many urban areas throughout the United States.

Will we solve the problems of teen pregnancy or high infant mortality among inner city residents by having less doctors available? No, of course not. Will we close the life expectancy gap between blacks and whites by having less doctors available? No, of course not. Am I trying to convince you that changing the law will solve these problems? No, of course not. But I am trying to convince you that without it, you can be guaranteed they won't be solved. The benefits of reforming the law could be great; the consequences of not changing the law are serious, long range and very costly. No one should be denied the right to compensation if he or she has been wronged. Nothing proposed in the legislation denies these rights. Not reducing the costs of frivolous suits and skyrocketing jury awards will deny those most in need of their rights.

Let me conclude by confessing that I would not be here if you hadn't worked right along side of me in the struggle for equal opportunity in America. I am a product of your equal opportunity dream. I am a minority physician of impoverished parents who wasn't supposed to break the cycle of poverty and who did. I overcame many obstacles with your help. This is one obstacle that I may not be able to overcome. It's out of my control. It's not a medical problem that I can solve. It's a legal problem. And, it's now in your hands.

Thank you.

The CHAIRMAN. Mr. O'Neill, we will turn to you now.

Mr. O'NEILL. Thank you very much for the opportunity of allowing me to present testimony to the Senate Committee on Labor and Human Resources on this very importent medical malpractice insurance issue facing us today.

My name is George O'Neill. I am executive director of Shawnee Health Service and Development Corp. It is a private not-for-profit organization that administers several regional health and social service programs in rural southern Illinois.

Additionally, we operate four Community Health Centers employing six full-time family physicians and dentists, serving over 12,000 patients annually.

Twenty-five percent of our patients are Medicaid patients; only 15 percent have health insurance, and most fall into the category of what has been called "the near-poor."

Recent medical malpractice insurance rate increases have caused us to consider eliminating routine obstetric care from our clinical practice, although it is a critically-needed service in rural southern Illinois.

In our case, premiums for physicians who performed more than 16 deliveries per year rose in 1 year 400 percent, going from an average of $9,000 a year to $38,000 per year per physician. That is identical to the rate charged obstetricians in our area.

The family physicians employed in our health centers have provided routine maternity care to their patients with affiliations for high-risk referral. Only one medical malpractice insurance claim has been brought against us in 7 years, and it was dismissed due to a lack of merit.

We perform 80 percent of the deliveries at one of our local hospitals. Consequently, when we considered eliminating obstetric care, the hospital announced that it would close its obstetric unit altogether, which would have forced 200 pregnant patients over to already overloaded obstetricians in a nearby community.

Faced with this dilemma, we temporarily avoided a crisis by raising our fees, absorbing some of the costs by reducing other services, and fighting the rate increase by enlisting the aid of the State Department of Insurance. We also worked with other physicians in the area and hospital administrators to try to gain a perspective of what was going on in the rest of our region.

From our analysis, we have learned that access to medical care in southern Illinois in general is being threatened by a combination of events stemming directly from unrestrained increases in medical malpractice insurance premiums.

The increases are due to a variety of reasons, as you have heard, depending upon one's point of view. But the one major result is always the same: access to appropriate obstetric care is diminishing, and our health care system is not prepared for the consequences, nor are they desirable.

For example, of the 26 hospitals in southern Illinois that provided obstetric care in 1980, fewer than 10 continue to provide this service today, creating 30- to 60-minute driving time for over one-fourth of the region's 400,000 population.

Effective December 1, 1986, the hospital in Pinkneyville, a small community of 10,000, will close its door to obstetrics as a result of the complete elimination of routine maternity care by all four of the community's family physicians. And there are no obstetricians in that county.

The consequences of reduced access are already profoundly affecting the poor in our region. In Cairo, for example, a community of about 6,000, and where unemployment reaches as high as 24 percent, pregnant mothers either drive 50 miles to Carbondale, go 40 miles out-of-State to Cape Girardeau, MO, or deliver in the emergency room.

We are just now beginning to see those obstetricians and dedicated family physicians who are continuing obstetric practice, restricting or closing their practice due to high volume.

And finally, we have evidence that deliveries in area emergency rooms are on the rise.

Interestingly, since August of last year, when Illinois' new medical malpractice law took effect, the State's second largest medical malpractice insurance company has collected over $1 million in premiums from physicians in our region and has not had a single credible claim of malpractice; yet rates continue to increase this past year.

The CHAIRMAN. Thank you, Mr. O'Neill. We appreciate it.

[The prepared statement of Mr. O'Neill follows:]

FINAL WRITTEN STATEMENT OF GEORGE O'NEILL, EXECUTIVE DIRECTOR
SHAWNEE HEALTH SERVICE AND DEVELOPMENT CORPORATION
MURPHYSBORO, ILLINOIS

Presented for the Medical Malpractice Hearing
before the
Committee on Labor and Human Resources
United States Senate
May 7, 1986

SUMMARY OF REMARKS DEALING WITH ACCESS TO HEALTH CARE PROBLEMS RELATED TO MEDICAL MALPRACTICE INSURANCE PRICE INCREASES

Thank you very much for the opportunity of allowing me to present testimony to the Senate Committee on Labor and Human Resources on the medical malpractice insurance issues facing us today.

My name is George O'Neill. I am the Executive Director of Shawnee Health Service and Development Corporation, a private, not-for-profit organization that administers several regional health and social service programs in rural southern Illinois. Additionally, we operate four Community Health Centers employing six full-time family physicians and dentists serving over 12,000 active patients annually.

Recent malpractice insurance rate increases have caused us to consider eliminating routine obstetric care, a critically needed service in our region.

In our case, initial premiums for physicians who performed more than 16 deliveries per year rose 400 percent in one year, going from an average of $9,000 to $38,000 per physician per year. The family physicians employed in our health centers have provided routine maternity care to their patients with affiliations for high risk referral. Only one malpractice claim has been brought against us in seven years and it is being dropped due to lack of merit. We perform 80 percent of the deliveries at one of our local hospitals, consequently when we considered eliminating obstetric care from our practice, the hospital announced that it would close its obstetric unit, which would have forced 200 pregnant patients over to already overloaded obstetricians in a nearby community.

Faced with this dilemma, we temporarily avoided a crisis by raising our fees, absorbing some of the costs by reducing other services, fighting the rate increase by enlisting the aid of the State Insurance Department, and working with other physicians and hospital administrators to gain a regional perspective on the problem.

From our analysis, we have learned that access to medical care in southern Illinois generally is being threatened by a combination of events stemming directly from unrestrained increases in medical malpractice insurance premiums.

The increases are due to a variety of reasons depending upon one's point of view, but one of the major results is always the same -- access to appropriate obstetric care is diminishing and our health care system is not prepared for the consequences, nor are they desirable. For example, of the 26 hospitals in southern Illinois that provided obstetric care in 1980, we expect that fewer than 10 will continue this service in 1986, creating 30 to 60 minute driving time for a fourth of the region's 400,000 population. Effective December 1, 1986, the hospital in Pinckenyville, which serves an area of about 10,000, will close its doors to obstetrics as a result of the complete elimination of routine maternity care by all four of the community's family physicians.

The consequences of reduced access are already profoundly affecting the poor in our region and are beginning to affect those with better financial means including adequate health insurance. As distances to routine care become greater (there is no public transportation), inadequate and delayed prenatal care will increase and mothers who have high risk pregnancies will find even fewer resources to choose from. In Cairo, a community of about 6,000 where unemployment reaches 24 percent, pregnant mothers either drive 50 miles to Carbondale, go 40 miles out of state to Cape Girardeau, Missouri, or deliver in the emergency room.
We are just now beginning to see those obstetricians and dedicated family practitioners who are continuing obstetric practice, limiting or closing their practice due

to high volume. If this process continues, deliveries in area emergency rooms will rise.

Interestingly, since August of last year, when Illinois' new malpractice law took effect, the state's second largest malpractice insurance company has collected over one million in premiums from physicians in our region, yet has not had a single credible claim of medical malpractice.

We have put enormous public resources into southern Illinois to improve pregnancy outcomes and health care delivery in general; The Family Practice Residency Program of Southern Illinois University Medical School, the Governor's Perinatal Care Initiative, and the federally supported Community Health Centers are prime examples. However,the threat of unrestrained increase in malpractice insurance rates is unraveling the fabric of obstetric resources available to us.

While the effects of increases in liability insurance rates on access to health care can be easily seen and documented, finding a resolution to the problem is complex and should involve the participation of physicians, lawyers, insurance companies, legislators, and patients. I am very pleased that Senator Hatch and the Committee on Labor and Human Recourses considers this problem a national priority and is taking steps to bring together these various interest groups to work on a long term solution. I feel, as I am sure you do, that "if you're not part of the solution, then you're part of the problem". It is no longer in the public interest to sit back and point the finger at the other guy on this issue.

I would strongly recommend that you provide states with incentives to develop appropriate tort reform, alternative dispute resolution systems, so that we don't have to litigate everything and hospital based risk reduction programs which include indemnification of physicians and hospitals involved in peer review. States which have not done so, should also be encouraged to review and adopt procedures for planning and licensure of birthing centers and physician extendors involved in routine maternity care. In fact, the public policy of treating pregnancy as an illness rather than as a "wellness" process needs to be re-examined.

Enacting these reforms alone will not directly affect exorbitant insurance costs without including additional measures which would strengthen regulation of the insurance industry, especially as it pertains to professional liability insurance. For example, state regulations should require prior approval by Insurance Departments for new rates and hold hearings or notify insureds when companies file rates with more than a certain percentage increase. In our case, we were not notified of a 400 percent increase until three months after it had taken effect.

In conclusion, I would like to say that while the right to sue a physician, hospital, or clinic should retain legal protection, certainly the administration of this protection should not outweigh the public interest in appropriate and accessible medical care. Our society is historically very slow in changing its institutions. "We find ourselves sometimes dealing through institutions of the horse and buggy age while facing problems of the era of explosive rockets" according to Rennard Strickland, Dean of the Southern Illinois School of Law. In his Waterfield Lecture, "The Lawyer As Modern Medicine Man", he makes the point that law as well as medicine is a human experience. He and the SIU Medical School are developing model joint programs in law and medicine. Perhaps other states should be encouraged to develop similar joint ventures as a way of bringing about changes through a better understanding of the human experience of pregnancy and our institution's ability to deal with it humanely.

The CHAIRMAN. This testimony has been extremely beneficial to the committee, from all of the witnesses.

Let me turn to Senator Dodd, who has been waiting, and then I will go to Senator Pell. I think I will submit my questions, in the interest of time, since we still have seven witnesses to go.

Senator Dodd.

Senator DODD. Mr. Chairman, first of all, I apologize for arriving late. We had hearings in the Foreign Relations Committee, as I am sure you know, this morning, so I was tied up there a little bit—although this is a form of "terrorism", I suppose, listening to the testimony, a different form of terrorism. It is a bit facetious, I guess, to say that.

But let me, if I can, Mr. Chairman, ask unanimous consent to have a copy of my opening statement included in the record.

The CHAIRMAN. Without objection.

Senator DODD. We have all heard the stories. You are making them very vivid, and we hear them in our own States. In fact, Senator Proxmire, you might be interested, has a son-in-law who is an obstetrician in Norwich, CT, where I am from, and he has quit the practice and is going to law school. He literally started law school. [Laughter.]

The CHAIRMAN. Now, that is a sad commentary.

Senator DODD. Yes. But you have helped this morning with this testimony.

I presume you have heard, if you have been in the room, as I briefly went through the testimony, that there has been some legislation introduced. In fact, Senator Danforth and I have worked over the last couple of years on various drafts of a bill dealing with product liability, which is related, obviously. But we have tried to come up with something other than just so-called reform of the tort system, and rather, an alternative claims route, assuming that most people who are injured would like to be compensated promptly for whatever losses they have suffered.

Now, obviously, a claims system does not get into pain and suffering which is a very legitimate claim for a bona fide plaintiff to make. But for those who would just like to recover whatever damages they may have incurred, lost wages, and the like, there ought to be a better system of allowing that kind of recovery, which we think could reduce substantially the amounts of the claims. In fact, claims in the relatively low area, according to some statistics, are in the neighborhood of 400 or 500 percent in excess of actual damages, whereas where you get into the very serious claims, the awards are 4 or 5 percent of actual damages—it is logic turned on its head there, in fact.

I wonder if any of you would like to comment on that at all as an approach. I realize it is our job—Dr. Mason, you said that very emphatically, and you are correct—but obviously, you have looked at this issue—whether you see caps on awards as the way to go, or Federal regulation of the insurance industry, or something like the alternative claims route we have talked about.

What sort of ideas would you bring to the committee?

Go ahead, Dr. Acosta-Rua.

Dr. ACOSTA-RUA. Yes. In the State of Florida right now, the Florida Medical Association is endorsing three bills that are in the

House and in the Senate, about caps, making a cap for pain and suffering, trying to separate what is the amount that should be given to a lawyer in the contingency fees. And I contacted many of the leading neurosurgeons in the State of Florida, and these things will solve some of our economic problems. The idea that I got from many of the neurosurgeons and myself is that the mediation panel will be a great tool to try to solve some of the frivolous suits. Such a panel would be formed by a lawyer, a physician and layperson. And if they intelligently can say that the suit has some merits right there, they can probably cut a lot of time and get to a conclusion of a certain amount of money, or take the case to the jury.

This mediation panel, as you know, was in Florida for a time, and then it was considered unconstitutional, I think.

Senator DODD. How did it work as a practical matter?

Dr. ACOSTA-RUA. It worked because it took away a lot of the frivolous suits. This is the great amount of time consuming of the real frivolous suits that——

Senator DODD. People used it, is what you are telling me?

Dr. ACOSTA-RUA. Yes, sir. It was used–it really stopped a tremendous amount of the time-consuming and frivolous cases.

Senator DODD. Thank you.

Dr. MASON. Senator Dodd, I think that we wholeheartedly support, obviously, the legislative initiative of the American Medical Association as well as the legislative initiative passed in the Illinois House last year, when we had our big Springfield rally. And I have enclosed all the details of that in the testimony.

I think we have to start with those things. I think the bill that Senator Hatch is proposing to make funding available for the implementation of those initiatives is also a very important component of it.

I do not profess that all of that is going to solve the problem. I think that what will happen is that we have to start with that and then observe what bappens for a while and make modifications and make whatever other changes are necessary as we see what happens in the malpractice climate.

Certainly, an alternative mechanism for taking care of some of the smaller claims would also, I think, be helpful in this situation, but I think that we have got to start with what we seem to have aright now.

Senator DODD. Yes, Dr. Rockett?

Dr. ROCKETT. If I could address that, California has four pieces of tort reform. That is, structured payments, collateral source, caps on contingency fees, and pain and suffering. We in Massachusetts now have a bill before the legislature. Included in that bill is a very new approach. It is called an early tender approach; it is a mini-no-fault, and it will only be addressed to obstetrical cases. What will happen is that the plaintiff will be offered a settlement within the first 180 days. If that is rejected, they can go the tort route. And in fact, if there is an award, it will be reduced by $50,000 as a result of their going the tort route and to dispel or to deter them from going that route.

We do not know if this will cost us more in funds, because there may be more suits brought. On the other hand, lawyers will be paid on an hourly fee. There will be a quicker settlement for the patient, and patients who truly have malpractice will be compensated.

We do not know if this will be the solution. We are willing to try this, and we would like to have more experience. We do not have experience to base it on.

Senator DODD. It sounds fairly similar to what we are talking about here.

Mr. O'NEILL. I would like to comment. In Illinois, of course, there is a constitutional challenge on the panel provision, but I happen to personally think that that is a good idea, and I hope that that challenge is not successful and that the panel concept will go through.

I think another thing that the Illinois law does not deal with is having the insurance industry more accountable. It does not really deal with the insurance industry per se; it deals more with tort reform.

But the State departments of insurance, at least in our State, are hampered by the amount of information that they can get from the insurance companies; about the claims, the type of claims experience——

Senator DODD. That is even true in Connecticut.

Mr. O'NEILL. I am sure it is true in a lot of States. But that may be something that has to be dealt with nationally.

Senator DODD. Yes.

Thank you all very much again for your very eloquent testimony this morning.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Dodd. I appreciate it.

Senator Pell.

Senator PELL. No questions.

The CHAIRMAN. I want to thank each of you for coming. I am going to submit questions to you, and I hope that you will get your answers in as quickly as you can, because we are making a record here that I think is extremely important, so your time has been well spent.

Thank you so much for coming. We appreciate it.

Our fourth panel consists of representatives from health care professional organizations. We will hear from Dr. James E. Davis, speaker of the house of delegates of the American Medical Association; Dr. James S. Todd, senior deputy executive vice president, American Medical Association, and Richard Epstein, senior vice president and general counsel, American Hospital Association.

Now, I have to apologize to you. I had committed 2 hours to this hearing, and it is now 2½ hours. And I have got about four conflicts with this right now, and I have got to be down at Health and Human Services. So I can only stay a little while longer, and I hope that you and the last panel will forgive me.

I am going to have to ask my counsel for the full committee, Mr. Ryan, to finish the hearing for me and take the testimony. It is very rare that I have to do that, but it is just one of those days where I just have to do it in order to get done what I need to do. I am going down to meet with Otis Bowen and others at HHS and I appreciate your consideration of me under these circumstances. I guess I probably sit through more hearings than any other Senator in the Senate. I do not know of anybody who comes close to this. I did not expect this hearing to take quite this long, but I also did not realize there were 18 witnesses, either, until I looked at the witness schedule last evening.

Sometimes we, in our eagerness, overdo it rather than underdo it. But I have to admit that every witness who has testified today has added to this hearing. So I personally appreciate it.

Let us begin with you, Dr. Davis, and take your testimony at this time. If I get up in the middle and turn it over to Mr. Ryan, please forgive me, and Dr. Wolfe and the others, please forgive me. I really had wanted to be here, but I will read what you say, and I will read your statements; I have not had the privilege of reading them yet.

Please go ahead, Dr. Davis.

STATEMENT OF JAMES E. DAVIS, M.D., SPEAKER OF THE HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION; JAMES S. TODD, M.D., SENIOR DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, AND RICHARD EPSTEIN, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, AMERICAN HOSPITAL ASSOCIATION

Dr. DAVIS. My name is James E. Davis, M.D. I am speaker of the house of delegates of the American Medical Association; and with me today is Dr. James S. Todd, senior deputy executive vice president, and Mr. Ross Rubin, of AMA's Division of Legislative Activities.

Mr. Chairman, you and the members of your committee have heard a great deal of testimony from both patients and physicians on the many issuse that we face, and so I would like to simply summarize some of our findings.

We do commend you, Mr. Chairman, for the leadership role that you have played by introducing S. 1804, very important legislation, and we thank you for that.

The CHAIRMAN. Well, thank you very much. We think it is important, too.

Dr. DAVIS. I appear before you today having viewed this problem from two perspectives. In speaking to you as a representative of the American Medical Association, I am speaking for hundreds of thousands of physicians in every type of practice across the Nation. But my views have also been focused and strengthened by the fact that as a practicing surgeon, I have cared for patients for years, and I have experienced a worrisome change in that relationship between physicians and patients because of the liability climate.

Let me review very briefly some fundamental conclusions gained from this experience.

First, there is undoubtedly a liability crisis. It affects doctors by forcing legal issues into medical practice. The crisis influences decisions and changes practice patterns, not always for the better. Doctors are taking early retirement as the crisis is literally forcing them out of their professions, whether they are actually sued or not, because of expense and psychological pressures.

Physicians are buffetted by dramatic increases in premiums, 44.8 percent in the last 2 years alone.

This crisis affects patients in a number of ways. First, perhaps their preferred doctor has changed or limited his or her practice as one third of the obstetricians in Florida, or 50 percent of the orthopedic surgeons throughout the country.

Second, the cost of liability premiums are passed on to patients, as well as the cost of so-called defensive medicine, which is better-defined as objective validation of clinical judgment, in case physicians find themselves later in a courtroom.

Finally, beneficial high-risk procedures might be avoided or even not introduced, and this ends up adding to the time and cost of patient care.

This crisis afffects the nation's pocketbook. Costs of medical profession liability are estimated from $11 to $13 billion per year, of which the Federal Government pays a significant proportion. Based on this, physicians have reached a conclusion that seems inescapable: Under current conditions, it is futile to expect a solution to the liability problem without attention being directed at the tort system. We have worked to improve the insurance system as far as we can, and we still have a problem.

We believe that to achieve stability, predictability, availability and affordability, there has to be a change in the tort system.

Let me state unequivocally, Mr. Chairman, that physicians are in favor of proper and reasonable compensation and justice for those who are injured due to the negligent or wrongful conduct of another.

The current system is slow, it is inequitable, it is expensive and has a lottery air to it. We need action now, and we urge the Congress to deal promptly and effectively with the liability issue.

Mr. Chairman, we endorse an approach of Federal incentives to States to assist them in adopting tort reforms, as well as improvements in risk management and medical discipline. S. 1804, introduced by you, Mr. Chairman, and several others, would strike the right balance in giving Federal leadership on a problem of Federal proportions, while leaving States with the responsibility for final action. It would bring rationality and predictability into our liability system, without denying the right of any patient to seek fair compensation.

Indeed, its provisions could well be applied to general liability problems, as well.

Our actuaries predict that this legislation, S. 1804, would save 28 percent in physician premiums alone. Enactment of S. 1804 would produce a more favorable climate in which to compensate injured patients, improve patient care, and preserve a healthy patient-physician relationship.

Without enactment of this legislation, Mr. Chairman, our health care delivery system may be damaged beyond repair. The crisis is here. The time, Mr. Chairman, for action, is now.

Thank you, sir.

The CHAIRMAN. Thank you, Dr. Davis.

[The prepared statement of Dr. Davis and responses of the American Medical Association follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Labor and Human Resources
United States Senate

Presented by

James E. Davis, M.D.

and

James S. Todd, M.D.

RE: S. 1804 and The Crisis in Medical
Professional Liability

May 7, 1986

Mr. Chairman and Members of the Committee:

My name is James E. Davis, M.D. I am Speaker of the House of Delegates of the American Medical Association. With me today are James S. Todd, M.D., Senior Deputy Executive Vice-President of the AMA and Ross N. Rubin, Assistant Director of the AMA's Division of Legislative Activities. The American Medical Association appreciates the opportunity to testify on the medical professional liability crisis in the United States today.

We commend you, Mr. Chairman, and this Committee for holding these important hearings to highlight an increasingly critical national problem. We would also like to acknowledge at the onset, Mr. Chairman, the leadership role you have played by your introduction and support for S. 1804, the Federal Incentives for State Health Care Professional Liability Reform Act. Your concern and involvement on a variety of health related issues have had a beneficial effect on the health and well-being of the citizens of our nation. You have accurately perceived that the professional liability crisis is adversely affecting the availability and the cost of health care in this country.

Although our testimony will focus on the crisis facing the medical profession, we are acutely aware that medical professional liability represents only one part of an overall liability problem in this country. Our situation is unique, however, in that this is not the first time that medicine has had a professional liability crisis. We have been experiencing an increasingly negative litigation climate for over a decade. Our situation is also unique in that the medical profession's liability crisis is affecting the availability and cost of quality medical care.

There are those who have tried to characterize our position as trying to deny justice to injured parties. Such claims are not true. Let me state unequivocally that physicians are in favor of proper compensation and justice for those who are injured due to the negligent or wrongful conduct of another.

This nation's civil tort system has been the channel through which justice and compensation have been obtained. We believe that the basic framework of our tort liability system has in the past worked reasonably well. Unfortunately, it is not working well today. It has become an erratic, expensive and unfair system.

Our tort system has historically had its limits. It was not designed to compensate all maloccurrences. It is supposed to require that some named individual or entity be found responsible for the injury in order to justify compensation. "Acts of God" or injuries that are entirely the fault of the plaintiff are not intended to be compensable through the civil tort process. The system, clearly, is not intended to provide compensation for all injuries or maloccurrences. The tort system has, however, been increasingly used to provide compensation where traditional tort theory would have denied an award.

In addition to the general expansion of negligence and other legal theories to provide greater degrees of injury compensation, the field of medicine has the added burden of meeting increasingly high expectations from patients and their families. No one can deny the astonishing progress we have made in this country in medical diagnosis and treatment with the concomitant decreases in infant mortality, increases in life expectancy and improvement in the quality of life of many through appropriate medical intervention. By every measure, the quality of medicine in this country has never been greater. However, an unfortunate side effect of these enormously beneficial developments is an increased level of unrealistic expectations by patients. Medicine is not an exact science and a desired outcome cannot always be obtained -- even when everything is done appropriately. This nation's 400,000 practicing physicians have the challenge of meeting the ever-increasing medical care expectations of 240 million Americans. Moreover, medical treatment of individuals can be complex and difficult and immediate action is often required. Misjudgments will occur and compensation should be made, but it must be reasonable.

Physicians have been and continue to be on the cutting edge of the liability problem facing the nation. New legislative solutions developed could have initial application in the field of medical professional liability. Problems that we have already experienced with increasing severity are now being faced by others. For example, physicians faced our first insurance availability crisis almost a decade ago. It is our view that adoption of the legislative proposals which we advocate will lead the way towards efforts to prevent the general liability problem from worsening. Medicine, however, cannot wait for all the problems of liability to be addressed. We need action now and so we urge the Congress to deal promptly and effectively with the liability issue.

THE CURRENT MEDICAL PROFESSIONAL LIABILITY CRISIS

The following facts clearly illustrate the gravity of the current medical professional liability crisis:

- The rate at which malpractice claims were brought against physicians in 1984 is roughly triple the rate at which claims were brought in the late 1970s.
- The size of the average verdict award against physicians has increased dramatically to $666,123 in 1984. Preliminary estimates are that the average jury award reached $1,017,716 in 1985. The number of million-dollar judgments per year has more than tripled since 1980.
- Premiums for physicians' professional liability insurance continue to rise dramatically. A few weeks ago in Massachusetts, physicians experienced an average 62% hike in their malpractice insurance rates. In Maryland, obstetricians saw their malpractice insurance rates increase by 130% last summer. For all physicians, premiums have increased by 44.8% in the last two years alone and by 236% in the last decade.
- Injured patients on the average receive less than 30% of every premium dollar paid by physicians for professional liability insurance.

- Because of the increasing numbers of claims and higher premiums, physicians are reacting by:

  . . . retiring early;

  . . . discontinuing medical practice;

  . . . restricting their practice to low-risk procedures;

  . . . choosing lower risk specialties for practice;

  . . . avoiding practice in localities where large numbers of medical professional liability suits are filed.

- A recent survey by the American College of Obstetricians and Gynecologists found that the economic pressures of malpractice suits have forced 12.3 percent of those surveyed to drop obstetrics practice. Those surveyed reported an average annual premium of more than $20,000. However, in Florida, obstetricians and gynecologists pay as much as $118,000 per year in malpractice premiums.

- A 1984 American College of Surgeons survey found that concerns over potential medical professional liability suits have influenced 38% of responding surgeons (50% of orthopedic surgeons) to refer more cases or to refuse to accept cases.

- Physicians are also reacting to the professional liability crisis by practicing "defensive medicine", a practice which includes ordering additional tests and procedures primarily in anticipation of a possible lawsuit. Studies indicate that 70% of physicians surveyed practice some form of defensive medicine. While some "defensive medicine" is good, much of it is not, and it is expensive.

COSTS OF PROFESSIONAL LIABILITY

The professional liability crisis not only is having a detrimental impact on physician practices and patient access to quality medical care, it also represents a significant and growing segment of the nation's health care bill. The costs of medical professional liability totaled an estimated $11 to 13 billion in 1984. These estimates suggest that costs generated by the current liability system were responsible for between 14.5% and 17.5% of the $75.4 billion spent on physicians' services in the United States in 1984.

It has been estimated that if the reforms contained in S. 1894 were adopted, the potential annual savings would be $800 million to $1 billion in premium costs alone. Huge additional savings would be achieved through the reduction of the practice of defensive medicine. The federal government, which pays for nearly 40% of the nation's total health care bill, would realize major savings.

FEDERAL INCENTIVES FOR STATE HEALTH CARE PROFESSIONAL LIABILITY REFORM

An AMA Special Task Force on Professional Liability and Insurance last year gathered data about the professional liability crisis and met with medical, legal and insurance experts. The Task Force's report constituted an action plan containing a series of recommendations in the educational, medical, legal, and legislative fields. The Task Force recommended federal incentive legislation to encourage the states to adopt substantive reforms to the tort system in order to alleviate the professional liability pressures while at the same time encouraging greater physician responsibility. This approach is intended to allow states, within general directions provided at the federal level, to develop tort reform proposals designed to meet each state's unique characteristics and needs. Out of these recommendations, an AMA draft bill was developed which formed the basis for S. 1804, a bill sponsored by Senators Hatch and Inouye and a number of other Senators. A companion bill, H.R. 3865, is pending in the House.

The reforms contained in this legislation also were recommended recently by the Attorney General's Tort Policy Working Group.

S. 1804 - The Federal Incentives for State Health Care Professional Liability Reform Act.

S. 1804 would provide federal incentives for states to adopt professional liability reforms. A state would be eligible to receive federal grants if the following tort reforms are adopted by the state and made applicable to cases involving health care malpractice:

1. Mandatory periodic payments for awards of future damages exceeding $100,000.
2. Reductions in awards for compensation received from other sources (eliminating collateral source rule).
3. Limiting awards for non-economic damages to $250,000.
4. Limiting attorneys' fees to 40% of first $50,000 of any award, 33.33% of next $50,000, 25% of next $100,000, and 10% of any further amounts in excess of $200,000.

These reforms are designed to attack the problem of windfalls and would leave the fault concepts and deterrence factors in the system. Experience in states which have enacted reforms in their tort systems has shown that reforms such as those called for in S. 1804 can reduce unnecessary expenditures related to professional liability claims while providing more rapid compensation for individuals.

These reforms would provide substantial savings. These savings are discussed in Attachment A.

In addition, to qualify for grants a state would have to adopt the following reforms:

1. Licensing fees from health care professionals would be allocated exclusively to the state agency responsible for disciplinary actions.
2. Hospitals would be required to have risk management systems.

3. Insurance companies in the state would be required to conduct risk management programs and require physician participation as a condition of maintaining insurance.

4. Insurance companies would be required to make data concerning malpractice awards available to state disciplinary agencies.

5. State law would have to provide for expanded and protected peer review activities by state health professional societies in conjunction with their respective disciplinary boards.

Other Reforms

The AMA and the medical profession are committed to weeding out incompetence. We do not, however, view incompetent physicians as the cause of the current crisis concerning professional liability. The typical medical professional liability case involves a good physician being sued for the first time. Physician incompetency is an independent problem which we have an obligation to address. Physician competency and discipline can be improved, but we need the tools. The process is already in place to conduct appropriate disciplinary activities, as seen in existing hospital peer review and quality assurance programs. However, greater resources are needed and anti-trust protection needs to be conferred.

Strengthening state licensing boards. Most states have legislation which gives state health professional licensing boards effective investigative and disciplinary powers. However, these boards must have adequate resources to fulfill their functions. S. 1804 would require, as a condition of receipt of the federal grants established in the bill, (1) that states provide that licensing fees from health care professionals would be allocated to the state agency responsible for disciplinary actions and (2) that insurance companies be required to make data concerning malpractice awards available to state disciplinary agencies.

Risk Management and Peer Review. There is no evidence that the increase in the number of professional liability claims and the severity of awards are related to a decline in the quality of medical care in this country. To the contrary, the evidence is that the quality of care and skill of physicians have never been higher.

However, negligence does occur, and effective risk management and peer review can reduce it. S. 1804 would encourage states to require hospitals to have risk management systems and to require insurance companies in the state to conduct risk management programs and require physician participation as a condition of maintaining insurance.

In addition, state law would have to provide for expanded peer review activities by state medical societies. This provision in S. 1804 seeks to strengthen public and private efforts aimed at detection and discipline of physicians found to violate professional standards. The bill encourages states to provide their medical disciplinary boards with the authority to enter into agreements with the state and county medical societies to permit them to review any malpractice action, complaint or other information concerning the practice patterns of any physician. Any such agreement between the medical board and medical society would not be grounds for any civil or criminal action under the antitrust laws of the state or under federal antitrust laws. This is important, since in the past when medical societies have attempted to engage in peer review and discipline they have at times been subjected to lawsuits and liability for treble damages. Appropriate physician self-policing activities need to be protected and encouraged.

CONCLUSION

In closing, Mr. Chairman, I again commend you for your active interest in this critical issue as shown by your sponsorship and support for S. 1804.

The AMA strongly supports prompt passage of S. 1804. We believe that its enactment will assist in establishing a more rational professional liability compensation system that will achieve substantial savings to the health care system (including the federal and state governments) while maintaining patient access to high quality health care. Of more importance, without enactment of this legislation our health care delivery system may be damaged to the point where repair will no longer be possible. The crisis is here. The time for action is now.

At this time I would be happy to answer questions from the Committee.

2551p

ATTACHMENT A
Discussion of Reforms Contained in S. 1804

Periodic Payments for Future Damages. Structured settlements with periodic payments for future damages over an injured claimant's lifetime, rather than a lump sum payment, should be required. Periodic payments are less expensive to finance and they assure that financial resources will be available to an injured person over time as needed. S. 1804 also provides that payments should end if a patient dies, thus eliminating "windfall" payouts to persons other than the injured person. Cases have been reported where multimillion dollar judgments have been awarded to cover lifetime expenses of parties who die soon after the award is granted. **Estimated savings of 6% in professional liability premiums alone could be realized from this reform provision in S. 1804.**

Elimination of Collateral Source Rule. The collateral source rule prohibits the introduction into evidence of any information about compensation a plaintiff may receive from sources other than the defendant. Therefore, plaintiffs may receive a double, triple or quadruple recovery for the same injury -- one from an insurer or employer or other source, and one from the defendant. S. 1804 encourages states to eliminate this rule so that awards would be offset by the collateral source recovery. Amounts spent by the plaintiff to obtain the additional compensation (such as insurance premiums) would be offset against any deduction. **Estimated professional liability premiums savings of 8% could be realized from this reform provision in S. 1804.**

Limit on Non-Economic Damages. Pain and suffering, mental anguish, and loss of consortium are examples of non-economic damages. These damages are impossible to ascertain accurately, can be manipulated by emotion, and are inevitably subject to speculation. They are a primary cause of the grossly distorted awards in professional liability cases. Non-economic damages should be limited. S. 1804 would provide incentives for states to limit non-economic damages to $250,000 in health care malpractice cases. Punitive damages would also be subjected to this cap. **Estimated professional liability premium savings of 12% could be realized from this reform provision in S. 1804.**

In this regard it should be noted that a 1984 opinion poll published by the AMA which found that three of four Americans aged 65 and over believe there should be a limit on awards. Half say that current awards are too high, and only 23% think most suits are justified.

Restriction on Attorneys' Contingent Fees. The American Medical Association does not recommend abolition of the contingency fee system. However, a sliding scale for such fees should be established. Customarily, attorneys accept personal injury cases, as well as professional liability actions, on a contingent fee basis. The attorney may receive from 25% to 50% of any award eventually won. Injured patients on average receive less than 30% of every dollar paid by physicians for professional liability insurance. The disproportionate nature of the attorney's contingent fee is compounded by the fact that there is often no relationship between the size of such fee and the degree of complexity of the matter and amount of legal skill and time devoted to the case.

S. 1804 would encourage states to enact a sliding scale for such fees, with declining percentages paid to an attorney as the size of the award increases. This would help assure that the appropriate proportion -- i.e., the bulk -- of the award goes as compensation to the injured party, not to the lawyers. At the same time, because of the larger percentage at the lower end of the award scale, lawyers would still be encouraged to accept cases with lower anticipated judgments. This would not, as frequently charged, deny or restrict patient access to proper remedies.

The American Bar Association, in a report on a five-year study that was issued in August, 1984, found that when lawyers reduce the amount of time spent working on a lawsuit, the savings are passed on to clients only if the clients are paying an hourly rate. When lawyers work on a contingent fee, "lawyers are benefiting," not clients, the report said.

Estimated state savings of 9% could be realized from this reform provision in S. 1804.

2551p/11

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AMA WASHINGTON
JOHN S. ZAPP, D.D.S.
Director
789-7400

June 25, 1986

The Honorable Orrin G. Hatch, Chairman
Labor and Human Resources Committee
United States Senate
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Hatch:

Attached please find the responses of the American Medical Association to follow-up questions in conjunction with the Committee's May 7, 1986 hearing on medical professional liability.

Sincerely,

John S. Zapp

John S. Zapp, D.D.S.

JSZ/dl

Attachment

AMA RESPONSES TO ADDITIONAL QUESTIONS SUBMITTED AFTER MAY 7, 1986 HEARING BEFORE THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE ON THE CRISIS IN MEDICAL PROFESSIONAL LIABILITY

1. Dr. Todd, I am delighted to learn from your testimony that "the AMA and the medical profession are committed to weeding out incompetence." I wonder if you could tell me how many disciplinary actions the state licensing boards brought against doctors for malpractice over the past year or whatever year for which data are available?

Answer: The AMA maintains, in its Physician Masterfile, records of all disciplinary actions rendered against any physician in the United States. We do not, however, track actions that are initiated against physicians where no final action has been taken. Nor do we have a break out of how many licensure actions are the result of malpractice. When we receive an inquiry about a physician who has had a disciplinary action taken against him or her, we refer the person making the inquiry to the state board which took the action for further details.

We do not believe that the formal grounds for the licensure actions necessarily reflect the extent to which state boards are weeding out incompetent physicians. Many times an action is taken for what, in effect, is incompetence but the formal basis for the action is one which is easier to prove.

For example, alcohol or narcotics abuse might be the basis for a license suspension or revocation in certain cases because establishing alcohol or narcotics abuse is an efficient and sure grounds for removing an incompetent physician from practice.

2. You state that antitrust protection needs to be conferred on health professional licensing boards in order to strengthen disciplinary actions. Could you elaborate on this point and give us any examples you have where antitrust laws have been used as a defense against disciplinary actions brought against physicians for malpractice?

Answer: Antitrust actions, or the threat of legal action against physicians who participate in hospital medical staff or medical society peer review have had a chilling effect on these activities.

- American Medical Association -
Department of Federal Legislation, Division of Legislative Activities

Antitrust law cannot be used as a defense to a disciplinary action for incompetence. State boards are insulated from antitrust actions by the "state action doctrine." But where hospital medical staffs or local medical societies attempt to police the profession the threat of extended litigation and possible treble damage exposure is enough to discourage physicians from performing this valuable function.

Recently in Astoria, Oregon, a surgeon sued several physicians who served on a hospital peer review committee that was reviewing the surgeon's hospital privileges. Although the surgeon resigned prior to any peer review committee determination, a jury verdict has resulted in a $2,300,000 antitrust judgment against the peer review physicians. The peer review physicians' professional liability carrier has maintained that their insurance does not cover antitrust damage awards. These physicians now stand to lose their homes and everything they have worked for because of their involvement with peer review. The outcome of this case may be reversed on appeal. However, the risk of involvement in such litigation, for such high personal stakes, is a powerful disincentive for physicians to become involved with peer review.

3. As an additional disciplinary measure, would you favor insurance companies using an experience rating system to surcharge doctors who have been successfully sued for malpractice?

<ins>Answer:</ins> Most insurance companies already use selective underwriting criteria and do not offer any coverage to applicants with multiple malpractice claims against them. And some insurance companies are using deductibles or other financial incentives designed to lower premium costs.

2619p

The CHAIRMAN. I am indebted to Senator Pell, who is willing to stay a little longer and chair the hearing; and when he leaves, he will turn over the remaining part of the hearing to our counsel, Bill Ryan.

Again, I want to apologize. This has happened very rarely in my—in fact, I cannot recall in this committee when it has happened, but it has happened as chairman of the Constitution Committee. I apologize ~~to you~~, and I want to thank my dear friend, Senator Pell, for being willing to help me on this occasion. And I want to apologize to you, Dr. Todd, and Mr. Epstein, for not being here to hear you, and also Dr. Wolf, Mr. Creasey, Dr. Pierce, and Steven Salman. I appreciate all of you being willing to help make this record.

With that, I will turn the gavel over to Senator Pell, and we can go to Dr. Todd, Senator Pell.

Senator PELL. Thank you very much, Mr. Chairman.

As you know, I am very glad indeed, and proud to be a cosponsor of this legislation with you. It is an interesting subject, and I will do my best. I will have to leave at about 1:15, and then will turn it over to Counsel.

The CHAIRMAN. We may be able to get through by that time. We are allowing just five minutes for each witness, Senator. Thank you.

Senator PELL. All right. Next would be Dr. Todd.

Dr. TODD. Yes, thank you, Senator.

First of all, we at the AMA do congratulate and commend both Senator Hatch and you for being willing to address this very difficult and complex problem.

Since our position is well-known, and since our formal statement is a part of the record, in the interest of time, I will be content to answer questions when you see fit, sir.

Senator PELL. Thank you very much.

Mr. Epstein.

Mr. EPSTEIN. Thank you, Senator Pell.

To outline the causes of the present crisis at this point in the day would be thoroughly redundant. I think we have heard some very persuasive examples and arguments about what is clearly a crisis.

I would like to take the few minutes that I have, Senator Pell, to address a related problem, and that is with respect to the legislation itself.

It is designed to alleviate, or contribute to the alleviation, of what we are all, I am convinced, persuaded is an increasingly critical problem in the national scene.

I would like to suggest that there is another player on the landscape. That is the development that was referred to by Senator Dodd when he was here a few minutes ago; that is, the matter of the product liability proposals. We see it both in the form of the efforts that have been made over the past 7 or 8 years to induce the Congress to address the problem of product litigation. We see it now very dramatically in the actual three legislative proposals of the Federal Government, the administration itself.

It seems to me that the matter of product liability has two aspects that we need to address. One is that it does add a dimension by way of fueling the inclination to address the problems of liability generally. However, there is a worrisome aspect to it, and I would like to call that to the attention of the committee.

We may be, in the medical malpractice area, left out of whatever efforts are made by the Congress to address the product liability issue. That concern is based on the assumption by those who are interested in and participating in product liability proposals to base their approach on the view that Congress has jurisdiction. In contrast, we have in each of the bills that address medical malpractice, a proposal to provide financial and other incentives for State-level action.

I would submit to the committee that this bill and other bills addressed to medical malpractice ought to include a straight-out acknowledgement that there is an appropriate basis under the interstate commerce clause for direct regulation of this area by the Congress for implementation at the State level.

Certainly, those engaged in any phase of malpractice problems, those engaged in any phase of medical and health delivery, are just as much engaged in interstate commerce as those who are engaged in product litigation problems.

The approach I suggest would serve to remove from the bills that have been introduced the elaborate apparatus for incentives and disincentives at the State level, which are improbable in a Gramm-Rudman world. Realistically, we cannot look forward to there being Federal funds available to provide the support for creating State incentives for past reform.

Therefore, I would urge that the committee relook at the basis for regulating at the State level by simply using the interstate commerce clause and the reality that indeed, the medical and health care system is engaged in interstate commerce. On that basis there can be designed either the half-dozen reforms that are represented in S. 1804, or any other combination of reforms that the committee believes would be helpful.

One caution on that, is that it needs to be versatile, so that, while there might be a threshold of reforms which the Congress might prescribe, there should also be an opportunity for States to pick up and enhance that threshold group based on their own communities, based on their own cultures, on their own needs, to add to it other reforms as well.

So we would see a diverse pattern, reflecting different regions and jurisdictions of the country.

[The prepared statement of Mr. Epstein and responses to questions submitted to him follow:]

American Hospital Association

AHA

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION BEFORE THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES ON MEDICAL MALPRACTICE LIABILITY

MAY 7, 1986

Mr. Chairman, I am Richard L. Epstein, Senior Vice President and General Counsel of the American Hospital Association. Our Association, which represents 5600 hospitals and 40,000 personal members, has been intimately involved with the issues surrounding the escalating problems of the costs and availability of medical malpractice insurance. On behalf of our membership I want to express our appreciation to you and this Committee for devoting your staff, your resources, and your valuable time to this critical issue, and for providing the opportunity to share with you our views on this subject.

You already have at your disposal the emerging quilt of state-level tort reform activity. While many of the states that are engaged in formulating legislation addressed to tort reform measures have not yet completed their work for 1986, it is nevertheless clear that two important developments are ripening: first, there is clearly an accelerating momentum of state-level activity that no doubt can be accounted for by the same environmental elements that cause the Congress to sharpen its focus on this malpractice insurance phenomenon. Second, as we observe the various reforms that are being massaged or are ready to be put into place, or are in place, we are caused to ponder the extent to which any and all the reforms will succeed in sufficient magnitude in actually lowering both insurance and health care costs, and in restoring the availability of reasonably priced medical malpractice and professional liability insurance coverage. Surely, these reforms can be expected to yield tangible improvement. Question: how far will that effect go, and how long will it take to realize the effect?

It would be redundant to the work of your staff to recite the litany of legislative proposals currently under consideration in the various state houses. We would, however, wish to use this opportunity to address three features of any federal legislation that, we feel, will be critical to the success of the federal role.

I.

We believe that the tendency in many quarters to identify the problem and to seek a solution (even tort reform) overlooks the distinctly multi-faceted nature of the present malpractice insurance phenomenon. We view the present situation as a confluence of several streams of contributing elements, and therefore as a problem that commands not one, but several major thrusts to effectively pursue a solution. While not all of the contributing elements lend themselves to a legislative remedy, we do believe that an appreciation of the multidimensional character of the situation is critical to designing an effective federal enactment.

What are these several facets? I would suggest there are at least seven. Perhaps we should start first with the patient/consumer. Manifest in the frequency and severity of medical malpractice claims and awards is the incredibly high level of public expectations of a no-risk world. What we frequently see as the basis of a claim or lawsuit is not a health provider's malfeasance, mistake, or negligence, but rather, the patient's disappointment in the level of success, or in the patient's unrealistic unwillingness to accept medicine as a mixture of art and science in which treatment is rendered by human beings, even whose most talented practitioners are not necessarily all-powerful.

In short, we submit that one of the results of the miracles of our technology is a society that naively has come to believe that life and survival can go unattended by the risks that are part of the ordained nature of this world.

The second facet: hospitals can do considerably better in the number, efficiency, and effectiveness of their risk-management programs. Identifying and addressing adverse patient incidents as close to the time of occurrence as possible helps measurably to determine the cause of and to address problems and untoward results occurring within hospitals. Such an approach is far more productive than allowing these matters to fester until they ripen unnecessarily into a claim or lawsuit with all the attendant expense, the potential for distortion, and the misplaced awards and remedies that have helped fuel the liability crisis.

A third facet is the physician community, which should be encouraged to make every effort to support and participate in hospital risk-management programs and especially to provide assistance in helping to weed out those physicians who may not measure up to professional standards and qualifications.

The fourth facet is the plaintiff's bar, which has directed so much of its efforts and substantial resources to what we would view as unwarranted finger pointing with respect to the problem, and a stubborn adherence to the status quo with all of its flaws and distortions.

The fifth facet would be the defendant's bar's failure to devote sufficient organization, energy, and resources to offset the efforts of the plaintiff's bar.

The sixth facet is the insurance community. We believe that a contributing factor to this multifaceted problem grows out of the investment and underwriting strategy engaged in by many insurers, some of whom, significantly, are no longer in existence. Finally, while we are looking across this broad spectrum of natural and quite human forces driving this crisis situation we should note that the judicial system has provided an unfortunate opportunity for what is too often misplaced theatre. Moreover, the judicial system, in too many instances, has allowed litigants to stray from the traditional doctrine of fault as the basis for compensation.

The point of the foregoing is to recommend that the process of crafting a federal role in this national problem must carefully avoid simplistic approaches to a situation with complex ingredients.

II.

The second feature of any federal legislation, which we feel will be critical to its success, is correcting the mistaken assumption regarding the jurisdictional basis for Congressional activity in state tort reform generally, and in the medical malpractice area specifically. All of the bills that have been introduced in both Houses of the Congress peg their authority to an incentive or disincentive system for the states to act. This conveys the mistaken notion that there is no constitutional basis for asserting Congressional jurisdiction, and hence, there has been established a carrot-or-stick approach as the only way to provide the legal framework for federal participation.

We would submit that that approach of incentives and disincentives is cumbersome and legally unnecessary. Moreover, where it requires expenditures it is unrealistic, as well. The interstate commerce clause of the Constitution certainly provides as solid a basis for Congressional activity in the malpractice arena as it presumably does in the product liability arena.

We are all aware that the interstate commerce connection in the case of the product liability bills is based on the correct theory that the frequently questionable and sky-high awards in the product liability area have an impact on the goods that are manufactured and distributed in the stream of commerce without regard to state boundaries.

But so, too, is there an impact on interstate commerce in the delivery of health care. For instance, through the volume of medical equipment and related goods that are purchased by hospitals and physicians; through the insurance purchased by hospitals and physicians; and through multihospital chains, group purchasing, and multi-state provider organizations. Moreover, the notion of either purchase or sale of goods in substantial dollar volume, as a basis for deeming an entity to be in interstate commerce, has a directly parallel precedent in the Federal Fair Labor Standards Act. That Act puts a hospital into "interstate commerce" for purposes of federal regulation of employees' wages and hours in any instance, and for all employers, when the annual dollar volume of business exceeds $250,000.

There would be no question that hospitals and physicians would clearly meet those requirements, thus recognizing that, not unlike the product liability nexus to interstate commerce, there is precedent for and reality in the provider nexus to interstate commerce.

I would caution that unless the jurisdictional basis of Congressional action regarding malpractice is clearly anchored to the commerce clause instead of to the carrot-and-stick approach, there is a substantial danger that the medical malpractice portion of the liability crisis may be left out of the reform movement.

III.

Finally, in considering any federal participation in this issue, we support tort reform that is likely to make a tangible contribution to alleviating the present problem. And we would look forward to any other appropriate federal action that is designed for the same purpose.

But we would also urge that no one particular set of reforms be mandated alike for all states. Rather, we would urge that there be a recognition of the differing cultures, histories, problems, and activities that characterize one or another state. Accordingly, we would urge that a federal bill in this area be similarly characterized by the kind of versatility that would allow each state to select from an array of reforms some combination of those that the particular state deems suitable to its particular environment, in conjunction with a threshhold of basic Congressional reforms.

IV.

Again, we commend the Committee for its attention to this issue. We must recognize that unless this problem is solved we risk the chilling of innovation and experimentation that have been an integral part of this nation's scientific and medical technology heritage.

We want to assist in any way we can. As one step, we will make available to the Committee the Report on Tort Reform of the AHA Medical Malpractice Task Force, which will be available for distribution on Monday, May 12th.

EPSTEIN EXHIBIT #1

COST AND PROBLEMS ASSOCIATED WITH MEDICAL LIABILITY INSURANCE AS IT AFFECTS AN URBAN FINANCIALLY DISTRESSED HOSPITAL

TESTIMONY PROVIDED BY BRONX LEBANON HOSPITAL CENTER
TO MR. JAMES PHILLIPS REPRESENTING SENATOR ORRIN G. HATCH

Mr. Allen Jerine

BACKGROUND

The Bronx Lebanon Hospital Center - a teaching hospital, is the largest single provider of health care services in the South Central Bronx.

- The Bronx Lebanon Hospital Center provides needed medical services to a high risk, socially and economically deprived community which has been Federally designated as a Health Manpower Shortage area.

- The hospital provides approximately 187,000 inpatient days of service and operates at 90% occupancy with the lowest length of stay (7.9 days) in the Borough. We provide over 272,000 Emergency Room and Outpatient visits each year.

- By every measurable health indicator, the South Bronx is a medically underserved area - our community has:

    - a ratio of 2.9 beds per 1,000 population for the South Central Bronx, as compared with 4.9/1,000 for New York City and 4.7/1,000 for New York State;

    - a primary care physician ratio of .45/1,000 of population for the Bronx as a whole while the local area has only a ratio of .05/1,000 population;

    - an infant mortality rate over 21/1,000 live births compared with 18.2 for the Borough and 17.9 for New York City;

    - a homicide rate of 38.5/1,000 (HPD A) and 46.0/1,000 (HPD B) as compared with 26.8 for the Borough and 19.0 for New York City;

- a death rate due to liver cirrhosis (usually associated with chronic alcoholism) in excess of 31/1,000 as compared with 27.2 for the Borough and 28.0 for the City;

- a population of which fully one-third are below Federally established poverty levels;

- immunization levels for South Bronx children first entering the public schools system are strikingly low compared to the rest of the City. A survey indicated that close to half these children were not protected against diphtheria, polio, measles or rubella;

- analysis of age-sex death rates per 1,000 population indicates that among Bronx children ages 1-4 the death rates are higher than those of New York City and the United States;

- the death rate of Bronx males, ages 15-44, is much higher than that of New York City and the United States as a whole. Specifically, Bronx males ages 25-34, have a higher rate of death due to hypertension and cerebrovascular disease than the nation and the City;

- the death rate due to tuberculosis for male and female Bronx residents is twice that of the national average;

- 23,764 patients were admitted to the hospital, for a total of 187,000 inpatient days;

- emergency room visits, which exceeded 69,000, accounted for 12% of all emergency room visits in the Bronx, making it the third largest in the Borough and the largest non-governmental operated emergency room in the Bronx. Almost 10% of all patients presenting at the hospital's two emergency rooms required immediate hospitalization;

- visits to the hospital's numerous outpatient clinics by community residents totalled approximately 203,000 the fourth most active ambulatory care program in the Borough, and the largest in a non-governmental facility.

IMPACT OF INSURANCE COST ON THE PROVISION OF MEDICAL SERVICES

The Liability Insurance, access and cost crisis threatens to limit the availability of Medical Services.

The gravity of the current liability and in particular, the malpractice insurance situation in New York State has created conditions that seriously jeopardize the delivery of health care services to those most in need of medical care. The problem of malpractice has gone beyond concerns of cost - we are now confronted with a loss of our most precious medical resource, the practicing physician.

physicians are reluctant to treat "risky" cases for fear of malpractice suits -- this could result in limiting access to care for those most in need of medical services;

- private attending physicians have disappeared from economically depressed areas -- over the past five years, we have lost over 30% of our active attending medical staff;

- one of our Pediatric Orthopedic surgeons has refused to treat children and adolescents below the age of 21 -- due to long-term malpractice risk and the cost of insurance premium for malpractice coverage;

- our Spinal Surgeon is reluctant to perform surgery due to the high risk attended to this type of surgery coupled with minimal reimbursement from medicaid and high malpractice premium;

- we find ourselves in a position where we have only one or two certified specialty surgeons such as vascular, pediatric, plastic and thoracic surgery;

- our residents and fellows leave the community and many leave New York State in order to establish practices in a less exposed and lower cost malpractice states or communities;

- almost all Board Certified Obstetricians and Gynecologists have abandoned the South Bronx -- leaving the responsibility of delivering babies to General Practitioners, Midwives and hospital based physicians;

- physicians are reluctant to handle difficult and complicated cases which may not be successful and leave them open to suit;

We are concerned as to the cost impact of malpractice insurance being experienced by our OB/GYN practitioners. Current OB/GYN premiums are $61,500 per year/practitioner for basic coverage and an additional $22,110 for excess coverage totaling $83,610/year/practitioner.

The cost of insurance coupled with limited restrictive reimbursement contributes to the loss of practitioners in the South Bronx. The Bronx Lebanon Hospital Center's OB/GYN group is the only voluntary practice in the entire South Bronx.

- the extent of high infant mortality and low birth weight is high in the South Bronx compared with the New York City average (mortality 21/1,000 live births in the Bronx Lebanon Hospital Center's catchment area vs. 17.9 for New York City).

- inadequate pre-natal care, defined as consultation before the last trimester of pregnancy, occurred in 31.9%

of the live births in the South Central Bronx. Inadequate pre-natal care affected only 16.3% of live births in the Bronx and New York City.

- The percent of births to teenagers (15-19) in the Bronx (19.0%) is increasing and is higher than New York City as a whole (13.9% of live births). Adolescent pregnancies are by definition high risk pregnancies.
- Our low birth weights or premature deliveries are about 14% as opposed to the National average of about 8%.

FINANCIAL IMPACT ON INNERCITY FINANCIALLY DISTRESSED HOSPITAL

The escalating cost of liability insurance has become an intolerable financial burden to the Bronx Lebanon Hospital Center.

Over the past five years or so, the cost of premiums for malpractice insurance mushroomed and the commercial marketplace for excess insurance for hospitals and physicians has rapidly become virtually non-existent. Much of the cost increase and lack of availability stems from alarming increases in the number and sizes of medical malpractice awards.

Between the years 1981 through 1986, our insurance cost increased from $1,839,832 to $4,574,808, a 248% increase. For the same time period, insurance costs expressed as a percent of annual budget has grown from 2 to 4.2%.

The cost of insurance remains an uncompensated expense.

Since 1981, we have operated under the New York State Prospective Hospital Reimbursement Methodology (NYPHRM).

- The base year for reimbursement is 1981.
- Emergency and outpatient charges are capped resulting in serious financial losses.
- Certain necessary costs incurred such as insurance in years 1983-85 are not included in the 1981 base year, which determines the rates currently being received.

- The recently enacted New York State Tort Reform law mandated hospitals to purchase excess insurance coverage for physicians. The out-of-pocket cost of this insurance, which was unbudgeted is close to $800,000.

- Trend factors which were designed to recognize inflationary costs ranged from 1.08 in 1981/82 to 1.34 for 1984/85.

- The cost of insurance during the same time period increased some 248%.

- The Bad Debt and Charity Care and the Distressed Hospital pools created by NYPHRM have not compensated the hospital for either increased insurance costs nor the cost of purchasing excess malpractice coverage.

The Prospective Payment System (DRG) for Medicare was introduced in New York State in 1986. There is no indication at this time as to whether this system will alleviate the expense problem associated with increased liability insurance costs.

The continuing escalation of insurance costs inhibits the hospital from maintaining or enhancing vital services.

The cost of insurance has an immediate impact on the hospital's ability to maintain or enhance needed services.

- 4.2% of our operating budget is expended for insurance--over $4,500,000.

- Physical plant continues to erode.

- Purchase of "state of the art" medical support equipment is delayed leaving the medical practitioner and the hospital further exposed to potential malpractice.

- Community outreach programs needed to reduce mortality and morbidity cannot be fully implemented.

- The purchase of certain capital equipment is forestalled.

- Dollars that should be expended to increase medical staffing are delayed (Increased medical staffing is necessary to adjust for the loss of community practitioners and regulatory mandated programs such as 24 hour/7 day licensed M.D. staffing of emergency rooms).

SOME SUGGESTIONS TO CONTROL ESCALATING LIABILITY INSURANCE COSTS

In 1985 New York State initiated a substantial number of changes to the State's Tort Reform law and medical malpractice insurance. However, this new legislation was incomplete and many concerns of the health care community remain unresolved.

- Cap pain and suffering.

- Abolish joint and severable liability - each defendants liability should be limited to his or her degree of culpability as determined by judge or jury.

- Create a medical Indemnity Fund subsidized by Federal/State Governments and malpractice carriers, which would pay for all of the plaintiffs future healthcare costs in excess of $100,000-- Health care providers should establish a "preferred provider" rate category to provide medical care at substantially reduced charges.

- Construct insurance rates to reflect individual physician performance rather than spreading the cost of claims settlement to the overall body of medical practitioners.

- Change burden of proof from "preponderance" of all evidence to clear and convincing evidence.

- Establish arbitration panels with the objective of rapid and reasonable claims settlement.

- Provide a mechanism that would fairly compensate hospitals for the cost of malpractice liability insurance and the costs associated with monitoring physician performance, risk management and quality assurance programs.

QUESTIONS FOR MR. EPSTEIN

1. MR. EPSTEIN, THE BRONX-LEBANON HOSPITAL CENTER IN NEW YORK CITY HAS PROVIDED MY STAFF WITH A FORMAL PAPER DETAILING THEIR MALPRACTICE INSURANCE PROBLEMS AND ASKED THAT THE PAPER BE ENTERED AS AN EXHIBIT AT THIS HEARING. WITHOUT OBJECTION, I'LL ENTER IT INTO THE RECORD AT THIS TIME. I FIND THIS A VERY COMPELLING STATEMENT AND I WANT TO READ EXCERPTS FROM IT AND GET YOUR COMMENTS ON WHETHER THE SAME KINDS OF PROBLEMS ARE BEING ENCOUNTERED BY OTHER HOSPITALS, MR. EPSTEIN. FOR INSTANCE, THE PAPER STATES THAT PHYSICIANS ARE RELUCTANT TO TREAT HIGH-RISK CASES BECAUSE OF THE FEAR OF MALPRACTICE SUITS AND THAT OVER THE PAST FIVE YEARS, THE HOSPITAL HAS LOST OVER 30 PERCENT OF ITS ACTIVE ATTENDING MEDICAL STAFF DUE TO THE MALPRACTICE INSURANCE CRISIS. IT ALSO SAYS THAT ALMOST ALL BOARD CERTIFIED OBSTETRICIANS AND GYNECOLOGISTS HAVE ABANDONED THE SOUTH BRONX--LEAVING THE RESPONSIBILITY OF DELIVERING BABIES TO GENERAL PRACTIONERS, MIDWIVES (AND MIDWIVES CAN'T GET INSURANCE) AND HOSPITAL-BASED PHYSICIANS. ARE THESE PROBLEMS COMMON TO INNER CITY HOSPITALS IN ANY OTHER BIG CITIES BESIDES THE BRONX IN NEW YORK, MR. EPSTEIN?

2. The Bronx-Lebanon paper also states that between the years 1981 through 1986, the hospital's malpractice insurance cost increased from $1.8 million to $4.6 million, a 248 percent increase. According to the paper, these insurance premium increases are uncompensated because of various caps on the fees the hospital may charge. Are increases of this magnitude being experienced by inner city hospitals in other cities and, if so, are any of them also having trouble passing on the increased costs of insurance to their patients?

3. Are these hospitals likely to be able to solve these problems if we aren't able to do something to abate the malpractice insurance crisis?

A.

4. Let me ask you the same question I asked Dr. Todd about experience rating for insurance premiums. Do you think surcharging doctors who have been successfully sued for malpracticd would be a good disciplinary tool?

A. (NOTE: He is against it--we ask this to begin a dialogue on this point. This will be important in next hearing.)

Responses to Questions

Question 1

Certainly, these kinds of problems are common to virtually all innercity hospitals, although obviously they will differ in the specifics and the degree. I would add also that the phenomenon of hospitals and attending medical staffs discontinuing a particular specialty service is not limited to innercity hospitals; it is true also of many small and rural hospitals.

Question 2

Again, the Bronx-Lebanon Hospital Center in New York City should not be viewed as a unique phenomenon. The impact of the malpractice insurance cost increase is shared by all hospitals, although it will differ in degree from one region to another and depending also on the array of services, patient mix, and service areas of a particular hospital.

Question 3

All problems are eventually solved in some fashion. Our focus should be on what the consequences are of those solutions. Are we willing, for example, to accept fewer services? Are we willing to accept the impact of higher costs? Are we willing to accept the kinds of consequences on patients and hospitals that we heard testified to by several witnesses this morning?

Question 4

I doubt that a fair system could be put in place to implement experience rating based on malpractice suits. For example, a surcharge would not turn an incompetent physician into a competent physician. Also, where a physician is sued and his insurance carrier settles the case, regardless of the physician's satisfactory performance, he would suffer an adverse experience rating unfairly. In other words, the administrative procedure that this suggestion would generate would be unwieldy, impractical and too often unfair.

Senator **Pell**. Thank you very much, Mr. Epstein. I had the chance to go over your testimony, which I benefited from, before. In connection with what you mentioned as the sixth facet, the community as a whole, I gather your thought is that there should be a more generic approach, where we are not only looking at medical malpractice, but various other kinds of liability regulations which should come into it, because you have product liability, which is causing just as many problems as medical malpractice in its own field.

I was curious what you thought could be the broad Federal approach here, given this one good example by calling for the regulation of the industry.

Mr. **Epstein**. Well, it is interesting that as you sit with the community of persons who are addressing problems in the product liability area and raise the question as I have, "Why are you overlooking medical malpractice?", the very earnest response is, "Well, gee, you know, product liability crosses State lines, but malpractice in the delivery of health care is a local phenomenon." That is the mindset of those persons who are involved in the development of product liability remedies.

The thing that we need to be afraid of is that we who are concerned in the medical malpractice issues are going to be left out of the product liability acitivity because of that mindset, and for the wrong reason. Not only is health care the third-largest industry in the Nation; not only is it, for all the persuasive reasons that we heard this morning, absolutely critical that we maintain the level and quality of health care in the United States, but it would seem that the efforts thus far at the State level are inadequate. We do need the participation of the Congress in this, and the Congress, it seems to me, does not need to tiptoe through a system of incentives and disincentives to induce States to get involved in this effectively, but rather, ought to mandate certain basic requirements.

Now, what are they? I think we could pick out a half-dozen of the dozen or 14 or 15 primary reforms and make those the threshold that the Congress would address. Those can be amplified on at the State level.

The question of which courts have jurisdiction is not a serious question. The State courts need to apply Federal law, or matters can be removed to the Federal courts. So the actual handling of litigation would not be a problem with that kind of setup.

I am afraid that no matter when action is taken by the Congress, we are going to see a period of 5 to 10 years before we will get the benefit of tort reform even at its best. And so the next point that needs to be made is that which you referred to in my paper, where I think each of these seven components of the health care field have a significant contribution to make toward this problem. In our case, I think it is risk management. I think we have heard the physicians discuss theirs. The insurers have not been present today, so we do not know how they would view their responsibility; the patient consumer's expectations, where they are unrealistic, result in removing resources from the system. The people we have heard this morning are jeopardized by that—each of these groups has some kind of contribution to make to the solution of this problem.

Senator **Pell**. Thank you very much, indeed.

Dr. Davis, or Dr. Todd.

Dr. **Todd**. Yes, Senator Pell, thank you.

Mr. Epstein makes a compelling argument for some sort of a broader approach. We share his concern that professional liability and medical malpractice may get lost in this big pressure of product liability.

But on the other hand, the provisions that are in S.1804, we know to be constitutional because they have been applied in other States and have survived the test of constitutionality.

Second, if it goes to a broad State preemption, which is really what he is talking about, that will be challenged in the courts for God knows how long on the constitutional issue. And, as Dr. Davis suggested in his statement, we need relief from this problem now, not 5, 10, or 15 years from now.

Senator **Pell**. Thank you.

Thank you all very much, indeed. We will take your thoughts very much into account. The chairman has asked that the record be kept open so questions can be submitted to you, and we look forward to your prompt reply.

Thank you very much, indeed, gentlemen.

Our fifth and final panel today is made up of specialists in risk management systems, who will tell us where we are and how far we still have to go in the field of quality assurance in medical care.

The panelists are Dr. Sidney Wolfe, director of the Public Citizen Health Research Group; Mr. Daniel Creasey, president of the Harvard Risk Management Foundation, accompanied by Dr. Ellison Pierce; and Mr. Steven Salman, senior vice president and Corporate Counsel of Sisters of Charity Health Care Systems, Inc.

As the Chairman has indicated, we trust you would limit your statement to a maximum of 5 minutes, and thank you very much.

Dr. Wolfe.

STATEMENT OF SIDNEY M. WOLFE, M.D., PUBLIC CITIZEN HEALTH RESEARCH GROUP, WASHINGTON, DC, DANIEL F. CREASEY, PRESIDENT, HARVARD RISK MANAGEMENT FOUNDATION, ACCOMPANIED BY ELLISON C. PIERCE, CHAIRMAN, COMMITTEE ON PATIENT SAFETY AND RISK MANAGEMENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS; AND STEVEN L. SALMAN, SENIOR VICE PRESIDENT AND CORPORATE COUNSEL, SISTERS OF CHARITY HEALTH CARE SYSTEMS, INC., CINCINNATI, OH

Dr. **Wolfe**. In December 1971, shortly after I started the Health Research Group, HEW was then having hearings on medical malpractice. I guess the ecclesiastical principle that "There is nothing new under the sun" applies once again. We have had recurrent problems, and the solutions that have been put forth really have not worked. It is now 17 years ago, since a 1,000-page report from Senator Ribicoff, concluded on this topic, "Most malpractice suits are the direct result of injuries suffered by patients during medical treatment or surgery. The majority have proved justifiable. These suits are the indirect result of a deterioration of the traditional physician-patient relationship." The quality of this doctor-patient relationship problem is certainly not addressed in these hearings, but it is a problem and it is, I think, going in the wrong direction. We need to do something about it.

I will just briefly summarize the findings that I presented in greater detail for the written record.

First, if you look for estimates as to how many people are injured or killed in hospitals alone as a result of negligence, you get estimates based on a study in Boston, which come out nationally, if they can be applied nationally, to 136,000 people a year. HHS in its own study found 203,000 a year. Whichever of these is correct, it only applies to hospitalized patients, and whichever is correct, they are vastly larger in number than the actual number of times a year that a patient recovers in a malpractice suit, which was only 16,000 times in 1983.

In other words, most of the time that people are injured or killed as a result of negligence in hospitals at least, suits are not even filed, let alone won.

Another study in the midseventies in California, looking again at these kinds of episodes in hospitals where injury or death occurred, also concluded that only about 1 out of 10 times that such an event happened was a lawsuit even filed.

So the point is that if you look at the broad picture, there are a lot of instances in this country in which people are injured or killed as a result of negligence; in only a small number are lawsuits deriving from them.

Recently—and I think this is a positive step toward the greater problem of how do you discipline doctors or hospitals better—the Government has chosen to make public data looking at differences between hospitals in terms of the mortality rates for coronary artery bypass surgery, and other procedures.

We analyzed this data, and I think the most striking finding which is shown on page 4 of our testimony, is that in the hospitals that were doing fewer than 60 of these operations a year, Medicare patients had a death rate of 20 percent; whereas the three hospitals in the country that had the lowest death rate—an average of 1.8 percent—-were doing over 350, an average of 400 bypass operations per year. Somewhere between, were hospitals that were doing over 100 a year on Medicare patients, which had a death rate of 11 percent—-still significantly high, but much lower than the death rate in the hospitals doing too few—fewer than 60.

The tragedy of this all is that in 1978, studies showed that you have to do at least a certain number of these operations in order to stay in practice, and recommended that hospitals that were doing fewer than that number should not continue doing them; that the operations should be regionalized. That obviously has not happened. Although the deaths many of these people who are killed during these operations do not result in a malpractice suit, they could, and it is an example of uneven quality of medical practice in this country.

Another thing that we focused on was mentioned earlier this morning in the context that Florida data also exists in Michigan and in Pennsylvania. In all three States' data shows that a small fraction of doctors account for a disproportionate share of the malpractice claims. In Pennsylvania, they call the repeat offenders—-

people who have lost three or four suits over the last 10 years—"hazardous physicians," and said that they should have a mandatory suspection of license. That kind of discipline has been talked about, but really has not been done.

The other thing I would also like to briefly review has also been alluded to by Senators Metzenbaum, Kennedy, and others—namely, the discrepancies between States in the rate of disciplining doctors. We just looked at this data for serious disciplinary actions and found that Utah, for example, had 37 times more actions per thousand doctors than Massachusetts. If all the States in the country disciplined at the Utah rate, which is not exactly high, we would have thousands more doctors being disciplined each year.

So in summary, there is a problem. You have heard some of the remedies. We would focus more on the ones having to do with increasing the discipline to doctors.

Just one final comment on the ob-gyn problem which everyone, for very good reason, talks about. Doctors in the United States took in about $80 billion in patients' fees in 1984. The malpractice premiums were about $2 to $3 billion a year.

The other professions, the other subspecialities within medicine, with the exception of neurosurgery and a couple others, are also paying a lot of premiums, but the doctors are still netting, after all these expenses, $100,000 to $159,000 a year.

So I think that in addition, as has already been suggested, to——

Senator PELL. Thank you very much, Dr. Wolf. Your time has expired. Your statement will be inserted in full in the record, and we will also keep the record open so that questions can be submitted at a later date.

Dr. WOLFE. Thank you.

[Responses of Dr. Wolfe to questions submitted to him follow:]

PUBLIC CITIZEN

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Answers to questions for Dr. Sidney M. Wolfe

1. *Is there any way to tell whether rates of medical self-discipline vary with the rate of malpractice?*

In order to answer this question, we must distinguish between the actual amount of malpractice--injury or death to patients as a result of doctor negligence--and the number of malpractice lawsuits actually brought or won by patients. Evidence cited in my testimony shows that for every winnable (by the patient) malpractice suit that is brought, 10 actually occur. There is no data on a state-by-state basis on the actual number of malpractice events but only on the amount of malpractice litigation. The amount of litigation or the amount of money paid out to plaintiffs and, if you trust the insurance industry, the rate of increase in malpractice premiums are the only indices by which to judge how much malpractice is occurring in a state.

In this context, it is useful to look at the rate of increase in malpractice premiums in several states and compare this with the rate of doctor discipline, referred to as "medical self-discipline" above. The states in which doctors are screaming the loudest about enormous increases in malpractice premiums, such as New York and Massachusetts, also are states in which the amount of doctor discipline, as measured by the rate of serious disciplinary actions by the state licensing board, (probation, suspension or revocation of license) is very low. New York was 34th and Massachusetts 41st out of the 50 states and the District of Columbia. In Utah, where there is a long tradition of good peer review by doctors in the form of one of the better PSRO's (now PRO's), and where the rate of doctor disciplinary actions exceeds that of any other state, the rate of increase in malpractice premiums is much lower than in states such as New York or Massachusetts. It is also instructive to look at California. In the mid 1970's, during the last malpractice crisis, California was one of the only states to pass legislation greatly strengthening the hand of the state in disciplining doctors. According to Los Angeles orthopedic surgeon David Horner, currently President of the Los Angeles County Medical Society, the increased amount of doctor discipline in California in the past decade is one of the most important reasons for the slowing in the rate of increase in malpractice premiums in California. Although the actual size of the premium is still larger than in many other states, the rate of increase in California is much less than in states such as New York, Massachusetts, Pennsylvania or other high population states which have not yet seriously tackled the problem of doctor discipline.

2. *What would be the effect of revealing the excess mortality information now available to PRO's? Can a patient now receive such information as part of informed consent? Can an insurance company receive this information for rate setting purposes?*

PRO data showing excess mortality in certain hospitals in comparison to others can be extremely useful in improving the quality of care in hospitals with sub-par records. For example, most, if not all, of the hospitals listed in Table 2 of my written testimony as having significantly high death rates for bypass surgery and also doing a very low volume of that operation should stop doing the procedure. If they did, the overall quality of care for bypass surgery would rise as a result of fewer hospitals each doing a larger number of these operations. Public disclosure of this data will hasten the decision to stop doing the operation at the hospitals not doing enough to stay in good practice.

I believe that patients should be able to get this data as a part of informed consent. At present, this is not easily possible.

Insurance companies, if they were in a risk-prevention mode instead of some other frame of mind, would get this information and use it as a wedge to accomplish the above-mentioned changes.

3. *Do insurance companies vary their premiums for clinics and hospitals with rigorous peer review?*

I am more familiar with efforts by a small number of insurance companies to experience-rate doctors than I am with efforts concerning hospitals. In Colorado, for example, the doctor-run insurance company which sells insurance to the majority of the doctors in the state charges lower premiums to doctors with better records and higher premiums to those who are not doing a very good job.

Senator PELL. Mr. Creasey.

Mr. CREASEY. Yes. I am Dan Creasey, president of the Risk Management Foundation at the Harvard Medical Institutions. We operate a malpractice insurance program for the Harvard medical institutions and 4,600 physicians.

I think that the malpractice problem can usefully be looked at as an issue of frequency of claims and severity of claims.

There has been much talk so far today, and usefully so, on the area of severity of claims, and the ways you can reduce this through traditional tort reforms, caps on pain and suffering, contingent fees, and other legislative interventions.

I would like to focus briefly on the issue of the frequency of claims, which is the real loss control problem. Dr. Wolf mentioned the large number of events which occur for which there are no suits brought and no compensation made.

Unfortunately, I think that situation is absolutely true; that is certainly our experience in Massachusetts, and what little national data is available supports that.

What that means is we have a ticking time bomb. There are a lot of events out there for which no compensation is made. Our current system is very slow, very expensive, and not compensating most of the people who are injured.

The suit yield from this pool of events unfortunately is increasing every year for the last 30 years, and there is no reason to assume that is going to change. So, one thing wrong with the current system is not only its current burden, but the direction it is going. Even though the quality of medical care by everybody's estimate is vastly better than it has been in the past, and getting better all the time—we can look forward to between two to four times as many suits, given the current level of care, as the forces which influence the bringing of suits unfold. These factors include more physicians, better patient awareness, changes in technology of medicine, and so forth. Consequently, we are going to have to run like mad just to stay even.

And so the health care system has to do a better job of reducing the frequency of maloccurrences.

The tort system can deal with the severity, but not the frequency, of malpractice claims in an effective way. Hospitals and doctors are going to have to work in a much more cooperative manner than they have in the past.

The current activities in loss control have been pretty basic. Probably 40 to 50 percent of the hospitals in the country do not have comprehensive risk management/loss control programs, and the other half do fairly traditional activities such as dealing with informed consent, educational programs, incident reporting, and so forth. These activities are useful, but are not necessarily getting at the fundamental problem of physician and hospital system errors which cause injury.

We must identify and analyze these injuries better, collect more comprehensive data, and get the medical profession on a specialty-by-specialty basis to begin setting standards of clinical practice specifically geared to reduce injury and improve patient safety. Unfortunately, part of accomplishing this objective involves something under the label of "cookbook medicine," and Dr. Pierce is going to speak about that in a minute.

But as far as the insurance industry is concerned, it should be required to provide much better claims data. We have got to give physicians much more information on claims than they currently have access to; we have to be able to collect it and provide it in a way that gives the insurance and health care industries some protection against discoverability, and, basically, the whole system has to shift up one more gear in the level of sophistication in the way in which it deals with these problems.

Senator PELL. Thank you very much, Mr. Creasey.

[The prepared statement of Mr. Creasey and responses to questions submitted to him follow:]

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Statement of Daniel F. Creasey
President, Risk Management Foundation
of the Harvard Medical Institutions

Before The

Committee on Labor and Human Resources
United States Senate
May 7, 1986

Mr. Chairman and Members of the Committee, my name is Daniel Creasey and I want to thank you for this opportunity to talk with you about the very difficult issues raised by the escalating costs of medical malpractice insurance coverage. I am president of Risk Management Foundation of the Harvard Medical Institutions which is owned by Harvard affiliated medical institutions and the University. Our insurance program was formed during 1976 medical malpractice crisis and currently underwrites malpractice insurance for the twelve Harvard affiliated institutions and 4,600 physicians.

I would like to take this opportunity to address an aspect of the malpractice problem which is often overlooked and underestimated; that is how to reduce the number of medical mishaps which can potentially turn into costly and time consuming litigation. This area is referred to in the insurance and health care industries as "risk management" or "loss prevention".

To better understand this concept, I believe it would be useful to look at the malpractice problem in two broad categories: (1) the severity of claims or how serious a particular injury is, and (2) the frequency of claims or how often mishaps turn into law suits.

Claims Severity

Assuming a patient files a malpractice claim, the severity issue simply addresses, "How much does it cost to get rid of the claim?". The two chief components that make up this cost are the expenses of litigation and the money paid to plaintiffs resulting from either jury awards or voluntary settlements. The escalation in size of average jury awards both in Massachusetts and the nation reflect a considerable level of social inflation. Short of major tort reform, it's reasonable to assume that the size of these awards will continue to increase. And although 90% of indemnity payments to plaintiffs in malpractice cases result from voluntary settlements out of court, the actions of jurors in those cases which come to trial strongly influences the value of all cases. Claims severity then could seemingly be addressed by legislative measures such as caps on pain and suffering, regulation of lawyers' fees and offsetting the amount plaintiffs receive from collateral sources of payments they are entitled to such as health insurance and unemployment compensation.

Reducing Claims Frequency Through Risk Management/Loss Control

I turn now to a matter which needs to be addressed in any federal or state solution to the problem; that is reducing the frequency of malpractice claims and the number of preventable injuries in the health care setting. Unfortunately, this aspect of the problem does not lend itself, even theoretically, to a straightforward or easy solution. Even though most people who are injured in the health care system don't sue, the number of claims has been steadily increasing each year. What makes this problem potentially so serious is that probably more than 80% of all patient injuries supposedly caused by negligence don't currently result in a suit. Given the large pool of "potentially compensable events" still existing in health care today, it is imperative that doctors and hospitals begin immediately to identify and deal with those mishaps which can be avoided through stronger laws which encourage, and not impair, a health care provider's ability to reduce preventable events.

Any serious effort to actually reduce the number of patient injuries must come from within the health care system itself. The hospitals can help but most of the meaningful loss prevention work will have to be done by physicians since they dominate the process of clinical care and are involved in most serious patient injuries. Since over 75% of the patient injuries which trigger law suits occur in the hospital setting, it's clear that most of the risk management activities should be coordinated in the health care institution. Unfortunately, our current legal and insurance systems actually discourage productive joint activity between doctors and hospitals for a number of reasons:

1. Physicians and health facilities are usually insured by different companies and are consequently "adversaries" following a medical incident;
2. Legal tradition all but requires separate defenses for a doctor and hospital involved in the same incident. This works against any meaningful process of mutual discovery following an incident;
3. Many laws and rules of evidence fail to protect all quality assurance and risk management records thus discouraging documentation of productive loss control activities.
4. Insurance companies have traditionally been unable to provide the level of clinical detail necessary for insured doctors and hospitals to define areas of potential loss and develop programs to reduce injuries.

What needs to be done

Because of these and other factors, while the loss prevention efforts to date have been somewhat useful, they tend to suffer from inherent limitations. The traditional risk management activities have concentrated on relatively easy targets such as securing affordable insurance, and improving safety standards, equipment maintenance, medical records, physician/patient communication as well as a broad range of educational programs. A far more difficult task is to directly reduce injuries which result from potential physican and/or hospital system failures in caring for and treating patients. I believe the following activities would make a significant contribution to controlling the malpractice problem:

1. Hospitals and their medical staff must develop formal risk managment programs, endorsed by the hospital trustees and medical executive staff, to identify and analyze all information on "potentially compensable events" and other mishaps including detailed data on open and closed malpractice claims. This information must be protected from discoverability or admissibility.

2. Physicians, by clinical specialty, must then work to aggressively reduce the number of preventable mishaps. This should include the development of specific clinical

standards for particular treatments or diagnosis. In effect, some elements of so-called "cookbook medicine" might be appropriate.

3. The development of such standards or loss prevention procedures should be integrated into hospital programs which routinely examine the credentials and competency of all providers at the institution. Once again, documentation necessary for this activity should be protected from potential discoverability or "fishing expeditions" by eager plaintiff attorneys.

All risk management/loss prevention activities must be regularly evaluated by providers and insurers to guarantee that issues of greatest priority are being addressed. To that degree, hospitals and doctors must be supported by vastly improved information about the injuries that are already occurring. Some of this information can come from health care institutions but most of it will have to come from medical malpractice insurers. The typical insurance company collects information for underwriting and actuarial purposes and is not able to provide adequate data to support a sophisticated loss prevention/patient safety program. Insurance companies should be encouraged to collect and process more complete data and to disseminate this information in useful form to the various relevant groups working to reduce the number of patient injuries.

Lastly, it is certainly true that some of the patient injuries are caused by incompetent physicians, but it would be a mistake to assume that fact to be the crux of the problem. The vast majority of injuries are caused by either failures within the health care system or the occasional negligence of generally competent physicians. In other words, the problem of the frequency of medical injuries is not principally a matter of bad doctors, but rather the case of adequate doctors who every now and then make a mistake. Reducing the number of these injuries, whether caused by bad doctors, good doctors or systems failures, turns out to be an extrordinarily difficult task.

The efforts of state medical boards in the area of disciplining bad doctors range between fairly ineffective to useless. Of the small number of official disciplinary actions taken each year, I would say the vast majority resulted from behavior such as theft, fraud or moral turpitude rather than clinical incompetence. To be fair, this state of affairs is almost unavoidable due to lack of funds, lack of timely information, lack of definitive competency standards and requirements of quasi judicial due process. Certainly the licensing authorities can do better, but we should be realistic in our expectations.

In summary, I believe that any Federal or State attempt to deal effectively with increasing malpractice litigation should include legislative provisions which will encourage and protect meaningful risk management/loss prevention activities conducted jointly by doctors and healthcare facilities. These provisions should address the systematic collection of comprehensive data on malpractice claims and potentially compensable events. Physicians, by clinical specialty, should be encouraged to work to develop standards and loss prevention procedures based on review of this problem-oriented data. All relevant procedures and standards should be used, in part, as a means for physician credentialing and reappointment in hospitals. And finally, all written documents related to these and related activities should be protected, on a limited basis, from discovery by third parties who might use this information to increase the number of malpractice suits.

QUESTIONS FOR MR. CREASEY

1. MR. CREASEY, WHAT PERCENTAGE OF THE HOSPITALS IN THIS COUNTRY HAVE ADOPTED RISK MANAGEMENT PROGRAMS?

A. ABOUT 60%

2. OF THESE, WHAT PERCENTAGE WOULD YOU SAY ARE EFFECTIVE?

A.

This is difficult to say without more reliable information. However, according to a recent survey conducted by the American Society of Hospital Risk Management (one of the American Hospital Association's fastest growing membership societies), nearly 25% of the hospitals responding said that risk management responsibility had been designated to a coordinator or director who in some cases also had responsibility for quality assurance. Another 25% said that risk management was the responsibility of senior management, and in more litigious states such as New York, Florida, Illinois and California, the presence of a full time risk manager is the rule rather than the exception. Many also have staffs of investigators and patient advocates and in some cases are part of the same department as the quality assurance and patient relations programs. These types of programs allow for more active involvement by physicians and, as such, are presumably more effective in addressing significant patient safety problems.

Senator PELL. Mr. Pierce.

Mr. PIERCE. Senator, thank you for providing me the opportunity to testify.

My name is Ellison Pierce, and I am an anesthesiologist, presently chairman of the American Society of Anesthesiology Committee on Patient Safety and Risk Management. I am also past president 2 years ago of the American Society, and currently president of the rather new foundation entitled Anesthesia Patient Safety Foundation.

I practice anesthesia in Boston, and am chairman of a department of an academic hospital, and an assistant professor at Harvard. I am insured by the insurance company Mr. Creasey just spoke of.

I will give you a summary of my views on the role of medical risk management in this problem. They are written in the formal statement which I submitted.

It indeed is a multifaceted approach that is needed therein. Risk management is only one part, but a very, very important part. The recognition of the need for risk management is spreading widely, and this has been greatly supported by the American Medical Association, the Council on Medical Specialty Societies, and other organizations.

I have had a 25-plus-year history of interest in anesthesia safety, and, just for example, from the Harvard Insurance Group, we have found that in anesthesia there are accusations of improperly administered anesthesia, improperly performed intubation of the trachea, and failure to monitor adequately.

But only a portion of all of these outcomes, as has been repeated today many times, is a result of negligence. We must not, then, confuse the issue of negligence versus unfortunate outcome.

At least in anesthesia and other areas in which I work, it is very ironic that the level of care, including our own very large liver transplant program, comes at a time when the malpractice problem would make it appear that medical care is not good.

In medical risk management, we should look at quality assurance, peer review, medical education, improved communications, and as your bill suggests, improving the actions of the State licensing boards, including giving them adequate funds with which to function.

The American Society of Anesthesiology has long had an interest in patient safety. It has many standards. It has an onsite consultation outfit to go and look at hospitals who request it. Our Patient Safety Committee works very closely with your Food and Drug Administration. We have set up a checkout list for anesthesia equipment. We have made a series of six videotapes on safety, patient safety, and anesthesia. We are looking at two studies, trying to examine the incidence of the problems.

The Society publishes a number of publications on safety in anesthesia and guidelines. The Professional Liability Committee is looking at closed claims. And lastly, just this past year, we established a committee to study standards of care to be published by the Society in the next year or so as we sift through the suggestions coming from all parts of the country.

Our Anesthesia Patient Safety Foundation has a mission to assure that no patient shall be harmed by the effects of anesthesia. We now have a newsletter coming out quarterly with materials from all over the world about this subject. We have established a grants program and encourage hospitals and individuals to apply for funds to study anesthesia safety in any way they wish. Our board of 30 is made up of anesthesiologists, individuals from the industry who supply our machines and drugs, insurance companies, FDA members, legal and risk management, the American Hospital Association, bioengineering, and we think it has gotten off to a resounding success.

And the problems can be solved only if we work in many directions. The anesthesia equipment people are trying to help, but they have their own very significant problems with product liability. Informed consent is an important part of it. And in Massachusetts, where you heard Dr. Rockett outline our difficulties, we are limited there because of lockins and freezes, placing caps on two-thirds to three-fourths of our patient income.

Thank you very much for asking me here today.

Senator PELL. Thank you very much.

[The prepared statement of Mr. Pierce and responses to questions submitted to him follow:]

STATEMENT OF ELLISON C. PIERCE, JR., M.D.
CHAIRMAN, COMMITTEE ON PATIENT SAFETY AND RISK MANAGEMENT
OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

PRESIDENT, ANESTHESIA PATIENT SAFETY FOUNDATION

PAST PRESIDENT, 1984, AMERICAN SOCIETY OF ANESTHESIOLOGISTS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
MAY 7, 1986

Mr. Chairman and Members of the Committee. My name is Ellison C. Pierce, Jr. I am a practicing anesthesiologist in Boston, Massachusetts, Chairman of the Department of Anesthesia at the New England Deaconess Hospital and Assistant Professor of Anesthesia at the Harvard Medical School.

I appear before you today as Chairman of the Committee on Patient Safety and Risk Management of the American Society of Anesthesiologists (ASA), a national medical society representing 22,000 physicians or other scientists engaged or professionally involved in the medical practice of anesthesiology. In addition, I appear as President of the Anesthesia Patient Safety Foundation, a multidisciplinary organization whose mission is to encourage activities that will prevent patients from being harmed by the effects of anesthesia. Lastly, I appear as a physician insured by a malpractice insurance program developed in 1976 by the Harvard medical institutions.

I am pleased to present views on the role of medical risk management in the solution of current problems with the cost and availability of medical liability insurance in this country.

If a solution to the current crisis is to be found, a broad multifaceted approach must be taken.

1. Society must establish reasonable and fair tort and judicial reforms, especially at the state level but with federal assistance.

2. Since, as many individuals have noted, one cause of the malpractice crisis is malpractice, physicians and hospitals must greatly intensify their efforts at quality review, risk management and patient safety endeavors.

3. We must explain the problem to legislators, attorneys, judges, health care administrators, physicians and the public. While reasonable compensation is clearly due patients injured as a result of negligence, physicians must not be made to pay for losses associated with untoward results when there is no negligence.

I have had, since the early 1960's, a strong interest in examining anesthesia mishaps and attempting to reduce their incidence. Therefore, I shall speak first concerning my own specialty and then turn attention to risk management in other areas of medicine.

Over the years, there have been many, many studies examining anesthesia morbidity and mortality. Recently the Risk Management Foundation of the Harvard Medical Institutions found the most common allegations of anesthesia negligence to include improperly administered anesthesia (32%), improperly performed intubation of the trachea (26%), and improper use of the anesthetic (18%). In addition, failure to monitor the patient's vital signs and improper use of equipment (9% each) were associated with more catastrophic injuries.

It is important that most medical societies now recognize the need for risk management in reducing the number of preventable medical mishaps associated with negligence and/or human error. However, it is again important to emphasize that only a portion of the adverse complications are the result of negligence. Or, put another way, adverse medical outcomes must not be assumed to be the result of negligence.

It is ironic that the current medical liability insurance crisis is occurring at a time when the level and quality of medical care in the United States is dramatically improving, in anesthesia and in other fields. The marked increases in medical liability claims and awards are, therefore, occurring in spite of improvement in the level of medical care. It should be apparent that a reduction in adverse events, whether or not inadvertent, preventable or negligent, will result in reduction of liability costs or at least a lessening in their rate of rise.

The broad field of medical risk management, then, includes quality assurance, peer review, continuing medical education, improved communications, and strengthened state licensing boards.

It is fortunate that anesthesiology, of all specialties, is most easily aided by stringent quality assurance mechanisms. For example, in no other field is the addition of "state-of-the art" equipment and monitoring systems so likely to assist in affording a dramatic decline in the number of mishaps. Clearly such good results will be seen in actuarial studies and lead to reduction in several jurisdictions where anesthesiologists have instituted vigorous safety programs.

Interest in patient safety on the part of the American Society of Anesthesiologists goes back a number of years, with the ASA House of Delegates having adopted guidelines for, among others, Delineation of Privileges in Anesthesiology, Patient Care in Anesthesiology, and Peer Review in Anesthesiology.

In addition, an On-Site Consultation Program responds to requests for evaluation of practices in anesthesiology at individual hospitals. Although I am not directly involved in implementation of this program, I am advised by colleagues in ASA that it has proven to be enormously popular with hospital administrators and medical staff personnel.

The Society has a Committee on Patient Safety and Risk Management which has provided advice to the Center for Devices and Radiological Health of the U.S. Food and Drug Administration in preparation of an FDA promulgated protocol, "Anesthesia Apparatus Check-Out Recommendation". The document encourages users to perform thorough inspections of anesthesia apparatus daily as well as abbreviated inspections prior to each procedure.

A major ASA undertaking has been the filming of a series of six videotapes on patient safety, entitled: Overview; Prevention of Disconnection in the Breathing Circuit; Anesthesia Machine Check-Out; For the Record: An Examination of Record-Keeping in Anesthesia; Mishap: Human Error in Anesthesia; On Trial: Adverse Outcomes in Anesthesia.

The Society also has made available a pamphlet, "Examples of Approaches to Risk Management"; a book entitled, Quality Assurance in Anesthetic Practice, by Stephanie Duberman, M.D.; and a manual, Peer Review in Anesthesiology.

In addition, the Committee is planning additional videotapes on the subjects of monitoring and equipment maintenance, as well as a multi-institutional study examining mortality and morbidity problems from current data generated at anesthesia department complication conferences. This is distinct from activities of the ASA Committee on Professional Liability which is performing a study evaluating the nature and incidence of anesthesia mishaps utilizing closed claim data from a number of medical liability insurance companies. In 1985 the Society appointed an Ad Hoc Committee on Standards of Care to review the entire issue of standards.

An independent organization, the Anesthesia Patient Safety Foundation, was incorporated in the fall of 1985 with a thirty-member Board of Directors. Fifteen Board members are anesthesiologists, including a number of well-known practitioners, department chairmen and investigators -- all interested in anesthesia patient safety and risk management. Others on the Board include prominent representatives from the anesthesia equipment and pharmaceutical industry, medical liability insurance companies, the Food and Drug Administration, the legal and risk management professions, the American Hospital Association, nurse anesthesia and biomedical engineering.

The mission of the Foundation is to assure that no patient shall be harmed by the effects of anesthesia. Its purposes are: to foster investigations that will provide a better understanding of preventable anesthetic injuries; to encourage programs that will reduce the number of anesthetic injuries; and to promote national and international communication of information and ideas about the causes and prevention of anesthetic injuries.

The ASA will annually underwrite, to the extent of $100,000, annual contributions by ASA members to the Foundation. In addition, individual memberships are available at $25.00 and corporate memberships at $500.00. Contributions on the part of manufacturers and others to the Foundation already exceed $300,000 for this year.

The first two undertakings of the Foundation, considered major risk management efforts, have been the establishment of a quarterly Newsletter and the awarding of funds for research in anesthesia patient safety. Among items to be included regularly in its publications are ones concerning patient safety research, educational materials, abstracts of the literature, questions and answers, foreign correspondence and various other activities supporting risk management and its effect on medical liability premiums.

Anesthesia research will be under the direction of the Foundation's Committee on Scientific Evaluation. The Grants Program will provide funding for clinical research directed toward enhancing patient safety. Its major objective is to stimulate studies leading to anesthesia methods which will completely prevent anesthesia mishaps. Areas of research interest include, but are not limited to, new clinical methods for prevention of mishaps and/or early diagnosis, evaluation of new and/or re-evaluation of old technologies for prevention and diagnosis, and identification of predictors of patients and anesthetists who are at increased risk for mishaps.

Research interest also includes development of innovative methods for study of low frequency events as mishaps, particularly in community hospitals, and methods for measurement of cost/effectiveness of techniques designed to increase patient safety.

As noted earlier, many medical organizations are very interested today in risk management. The American Medical Association (AMA) and the Council of Medical Specialty Societies (CMSS), especially, have emphasized the need for loss prevention and patient safety. They emphasize that tort reform is not the whole answer.

The CMSS several years ago initiated a patient injury prevention program, emphasizing the sharing of responsibility for untoward events with the patient and the need to improve doctor communications. They have prepared a four-set sound/slide series on patient injury prevention entitled: Courtrooms are for Lawyers, Not Doctors; Informed Consent: Its Meaning and Application; Good Medical Records Are Good Medicine; Physician-Patient Communications.

Every medical specialty is involved in the crisis. The surgical specialties have higher awards but the medical specialties have more claims. The AMA places very strong emphasis on risk management. The AMA's James S. Todd, M.D. noted that risk management means behavior modification for physicians, but that when you show them facts about injury and treatment errors, they are willing to change.

What are the overall problems? The major ones include diagnostic errors, improperly performed procedures, anesthetic injuries, drug injuries, therapeutic errors of omission or commission, and failed sterilization.

Among the risk management approaches being adopted by various specialties are the following: case conference discussions, morbidity and mortality rounds, grand rounds, peer review, improved credentialling processes, notification of potential claims, incident reports, critical event reporting, and generic screening. A problem assessment should include early notification to the insurance company if there is a potential claim, as well as thorough review by the chief of the department.

James F. Holzer, M.D., Director of Loss Control at the Foundation, in a review notes, "Historically, risk management and quality assurance were treated as having separate and distinct operational objectives and functions . . . There is a growing rationale to integrate the two functions . . ." He lists four essential activities in the process of risk control: problem identification, problem assessment, problem resolution and problem evaluation.

Problem resolution should include change in physician practice, procedures and behavior, change in department policies and procedures, change in staffing patterns and work schedules, review of provider performance, and imposing sanctions or practice limitations, if appropriate. In addition, underwriting incentives are often warranted. These may include improved monitoring and advanced training as prospective approaches, and increased rates for individuals with frequent claims as a retrospective response.

It is also important to note the role of increasing product liability problems in medical risk management. Clearly research, development and technological advances are hindered when corporations are not able to control product liability losses. In my own specialty of anesthesia, only two manufacturers are left selling anesthesia machines in the United States, one major firm having discontinued their production some months ago because of product liability difficulties. It is my impression, moreover, that the two companies now extant have enormous liability losses and that their discontinuance of anesthesia machine manufacturing is possible.

That the need for informed consent is relevant in risk management has been firmly established. Failure to provide adequate information to the patient may constitute professional misconduct. It is a wide-spread belief that well-informed patients who have participated fully in the choice of therapy and still have had a bad result will be much more likely to accept the result without filing suit.

Informed consent consists of describing the nature of the patient's condition, the nature of probability of risks, the benefits to be reasonably expected, the likely outcome of no treatment and alternatives to the treatment. Informed consent must be obtained for all major therapeutic and diagnostic procedures where disclosures of significant medical information, including material risks, would assist the patient in deciding whether to undergo the proposed procedure.

It should be noted that in my own state of Massachusetts, the cost for medical liability insurance premiums has sky-rocketed. This has made much more difficult for me as a department chairman the problem of attracting top-notch anesthesiologists. A large number of superior residents in anesthesia from the Harvard hospitals leave Massachusetts.

Although many states, of course, have problems with the cost of liability insurance, Massachusetts is the only state in which it is not possible to pass through the increasing cost of the insurance. This is because of laws requiring acceptance of assignment in Medicare patients, as well as with Massachusetts Blue Shield patients. In most hospitals, these two categories make up some 75% of the patient population.

It is discouraging to receive an advertisement from a recruiting firm in Oklahoma pointing out the turmoil physicians in Massachusetts are experiencing and inviting anesthesiologists to contact the firm to find positions in other states. A copy of the advertisement is attached.

In addition, once risk management and quality assessment have indicated a possible incompetent physician, it is often very difficult to do anything about it because of the likelihood of suit on the part of the physician being disciplined. Moreover, we expect medical societies to provide education and discipline for their members, but the fact often is overlooked that some 40% of the doctors in the country do not belong to the American Medical Association or their state society.

I have attached a review of the role of anesthesia risk management in reducing preventable anesthesia mishaps published in the Risk Management Foundation FORUM. It concludes with comment, "It may be appropriate to paraphrase from the January 28, 1985 NEW YORK TIMES article about the recent disaster at a chemical plant in India that killed 2,000 people. The TIMES noted that the accident resulted from design flaws, maintenance failures, training deficiencies and operating errors. Likewise, anesthesia mishaps seldom occur as a result of a single cause, but rather are complex events." However complex the problem, I believe that risk management represents perhaps the single most promising opportunity for dealing with professional liability problems in my specialty.

Reducing Preventable Anesthesia Mishaps: A Need For Greater Risk Management Initiatives

By Ellison C. Pierce, M.D.

Editor's Note:

In spite of the relatively low number of anesthesia mishaps in the United States, there continues to be concern over the increasing seriousness and frequency of malpractice claims against members of that profession. In this special issue of FORUM, Dr. Ellison C. Pierce discusses the need for major risk management initiatives on the part of organized medicine and the healthcare industry to reduce the incidence of anesthesia morbidity and mortality.

Known throughout the world for his interest in researching anesthesia mishaps, Dr. Pierce is coauthor of a recent book published by Little, Brown and Company entitled "Analysis of Anesthetic Mishaps" (1984). He currently serves as chairman of the department of anesthesia for Deaconess Hospital in Boston and is the immediate past president of the American Society of Anesthesiologists.

In his article, Dr. Pierce offers several specific recommendations to further enhance the quality and safety of anesthesia services in hospitals.

JFH

Anesthetic morbidity and mortality have been the subjects of discussion and debate since the first reported anesthetic death in 1848 at New Castle, England. The mishap occurred only fifteen months after Morton demonstrated the use of ether at the Massachusetts General Hospital. Today, out of some twenty million anesthetics administered annually in the United States, the incidence of mortality related to anesthesia is believed by most authorities to lie in the range of 1 per 10,000 to 1 per 4,000, that is, some 2,000 to 5,000 deaths per annum. In addition, there are a number of anesthetic mishaps, perhaps in the same range as in the death rate, which result in severe morbidity such as permanent brain damage. The seriousness of these figures is readily perceived when one notes the following:

1. Although the percentage of anesthetic medical liability claims is only some 3 or 4% of the total in all of medicine, the indemnity paid approaches 10% — a fact obviously related to the severity of the injuries.
2. Most authorities believe that more than 50% of the mishaps are preventable.
3. Human error, rather than equipment failure, appears to be the primary factor in most preventable cases.

It is of utmost importance, however, that all parties — the public, attorneys, insurance companies, the government and physicians — recognize that not all adverse events during anesthesia are a result of error (and preventable). Rather, an unknown number are due to patient disease or idiosyncrasy; anesthetists must not be unfairly blamed for these.

Moreover, it is important to stress that in recent years, with ever improving techniques, anesthesia morbidity and mortality have declined significantly, while sicker and sicker patients are undergoing increasingly more difficult and complicated surgery, such as open heart procedures and organ transplants.

What are some of the problems currently preventing further effective reduction of avoidable mishaps?

Major Impediments

1. In the United States, in contrast to most other English speaking nations, satisfactory reporting systems — mandatory or otherwise — do not exist. Current data, meager at best, come from analysis of insurance claim files and critical incident studies (Cooper et al).
2. The variability of opinions among members of the profession concerning methods to reduce morbidity and mortality make difficult the development of consensus regarding standards of practice in anesthesia. Significant differences of opinion and patterns of practice exist among anesthesiologists. Many authorities advocate installation of sophisticated delivery and monitoring systems (as in the airline industry), while others strongly oppose this approach, convinced that safe anesthesia is a result of constant vigilance using relatively simple techniques.
3. Cost containment is a major, if not the major factor preventing adequate development, utilization and maintenance of equipment and systems at "state of the art" levels.
4. For an individual anesthetist or hospital, an anesthetic mishap is a very rare event — a fact that greatly reduces continuing interest in the problem among hospital medical staff and administrators. However, no matter how few the number of anesthetic deaths or severe the injuries, an individual occurrence is 100% significant for that patient and the family. Few institutions — hospitals, anesthesia departments, professional societies, insurance companies, the Joint Commission on Accreditation of Hospitals, government — are paying enough attention to the problems.

In examining some of the potential solutions, it is important to note that monies needed for their implementation are not great when compared to medical liability costs and expenditures for long term care of the injured.

Compulsory Reporting

First, establish mandatory systems for reporting anesthesia mishaps at local (hospital), regional and national levels, primarily to provide data showing the types and frequency of problems. This would allow anesthesia departments to take corrective action in risk management meetings evaluating mishaps, encourage manufacturers to develop safer apparatus, promote insurance companies to scale premiums, lowering costs for the safe anesthetist, and allow anesthetists to choose anesthesia techniques on a better statistical basis.

Uniform Standards

Second, there should be a greater emphasis locally and nationally on developing recognized standards for the safe practice and administration of anesthesia. Such standards might include the development of safer anesthesia machines with emphasis on human factors design issues and safety-performance criterias well as better *integrated* monitoring systems (as advocated by Duberman and Bendixen).

Many authorities believe that monitoring should include electrocardiography, oxygen analyzers, capnometers, disconnect and high pressure airway alarms, automatic blood pressure recording (non-invasive whenever satisfactory), temperature and, in the near future, pulse oximetry. They recognize that the use of some of these devices is not possible in every anesthetic technique and that monitoring in no way replaces vigilance on the part of the anesthetist but rather augments it; any anesthetist *can* make a mistake which may be detected by an alarm before harm occurs.

Fail-Safe Technology

Third, providers should recognize that cost-effective anesthetic practices actually require using the most up-to-date and well maintained equipment. Duberman and Bendixen estimate that the cost of an adequate fail-safe system is about $7.00 per case.

Multidisciplinary RM

Lastly, problems of anesthesia mishaps should be vigorously attacked at every level.

1. Hospitals and departments of anesthesia should:
   - Include anesthesia equipment in risk management programs. This requires periodic testing and prompt repair by professional technicians under the supervision of biomedical engineers, mandatory use of preoperative check lists by operators, documentation and historical reporting of problems, and well designed inservice programs.
   - Replace obsolete anesthesia machines and monitoring equipment. Authorities estimate ten years to be the safe, useful life of an anesthesia machine.
   - Establish effective morbidity and mortality conferences utilizing data collected from occurrence screening as well as from a listing of all critical incidents. In addition, devote meetings periodically to overall patient safety issues.
   - Include in educational endeavors emphasis on engineering and functional aspects of anesthesia equipment which will result in better recognition of impending mishaps and methods to prevent them.
   - Develop standards of practice. The Harvard Anesthesia Department Risk Management Committee has written a first set of proposals recently approved for implementation by the Chiefs of Anesthesia at Harvard hospitals. (See article page 2).
   - Develop specific protocols, including guidelines for the conduct of an exchange of anesthesia personnel and for anesthesia machine inspection procedures.
2. The American Society of Anesthesiologists, the American Medical Association and the Council of Medical Specialty Societies should intensify their efforts at promoting patient safety through strong educational programs for their members as well as continue evaluation of the effect of medical mishaps on ever increasing medical liability premiums.
3. Medical liability insurance companies should lower premiums for anesthesiologists and hospitals utilizing effective anesthesia risk management programs, superior monitoring systems and proper standards of practice. In addition, insurance companies with adequate statistics should be able to recognize which departments or individual anesthetists sustain repeated mishaps and consider the addition of premium surcharges. Also, companies not yet participating should consider sharing their claims experiences in a new program on identification of anesthetic complications organized by Dr. Richard Ward at the University of Washington, Seattle, under the auspices of the Committee on Professional Liability of the American Society of Anesthesiologists.
4. The Joint Commission on Accreditation of Hospitals should increase its interest in anesthesia safety to the same level it applies to fire prevention (safety doors), working through the Committee on Peer Review of the American Society of Anesthesiologists. Unfortunately, only by regulation will some anesthesia departments develop adequate standards of safety.
5. Local and state governments should recognize anesthesia mortality and morbidity as the public health problem that it is and establish statistical reporting systems. The Federal Drug Administration has recently issued a regulation requiring manufacturers and importers to report device-related deaths and serious injuries. The FDA should also continue to enlarge its embryonic reporting system for practitioners to record adverse anesthesia events, working with the United States Pharmacopeia and the American Society of Anesthesiologists. Details of this program will be announced soon in the ASA Newsletter.

It is interesting to note that the anesthesia profession has many similarities to the airline industry. The latter has simply taken better advantage of risk management techniques and other technological advances. These include pre flight (pre operation) check lists and other protocols, training in management of emergencies with "in flight simulators" and recording and tabulation of critical incidents (including the black box in-flight recorder). Perhaps this is why in the United States, the average annual death rate from 1975 to 1980 for major commercial jet flights is only 177 fatalities for one million departures per year.

In summary, it may be appropriate to paraphrase from the January 28, 1985, *New York Times* article about the recent disaster at a chemical plant in India that killed 2,000 people. The *Times* noted that the accident resulted from design flaws, mainte-

continued on page 8

Reference *FORUM*

The following information on relevant articles and books is provided to readers as a regular feature of FORUM. The editors solicit your suggestions and reviews of literature you feel would be of value to individuals involved in hospital risk management.

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Conferences & Symposia

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EDUCATIONAL CONFERENCE — MASSACHUSETTS ASSOCIATION OF QUALITY ASSURANCE PROFESSIONALS — April 2, 1985, Boston, MA. Contact the New England Hospital Assembly, Inc., P.O. Box 736, Osterville, MA 02655.

EDUCATIONAL CONFERENCE — MASSACHUSETTS SOCIETY FOR HOSPITAL RISK MANAGEMENT — April 3, 1985, Boston, MA. Sponsored by MSHRM c/o Joan Gaff, Massachusetts General Hospital Treasurer's Office, Box 135, Boston, MA 02114

MEDICAL RECORD ANALYSIS: A RISK MANAGEMENT PERSPECTIVE — April 3, 1985, Boston, MA. Sponsored by the New England Hospital Assembly, Inc., P.O. Box 736, Osterville, MA 02655.

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THE EVALUATION AND TRIAL OF MEDICAL MALPRACTICE CASES, INCLUDING ANESTHESIOLOGY AND BRAIN-DAMAGED BABY CASES — April 19-20, 1985, New York, NY. Sponsored by the Practicing Law Institute, Department UW, 810 Seventh Avenue, New York, N.Y. 10019.

NATIONAL INSTITUTE ON HEALTH LAW AND ETHICS — April 25-26, 1985, Boston, MA. Sponsored by the American Society of Law and Medicine, 765 Commonwealth Avenue, Boston, MA 02215, and the New England Hospital and Health Foundation.

THE INSTITUTIONAL ETHICS COMMITTEE: ITS ROLE AND FUNCTION — April 27, 1985, Boston, MA. Sponsored by the American Society of Law and Medicine, 765 Commonwealth Avenue, Boston, MA 02215.

Preventable Anesthesia Mishaps

continued from page 7

nance failures, training deficiencies and operating errors. Likewise, anesthesia mishaps seldom occur as a result of a single cause but rather are complex events. ■

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Duberman, S.M. and Bendixen, H.H. Concepts of Fail-Safe in Anesthetic Practice. In Analysis of Anesthetic Mishaps, eds. Pierce, E.C., Jr. and Cooper, J.B., Little-Brown, Boston, 1984.

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New Phone Number for Risk Management Foundation

Please note that the phone number for the Foundation has changed from (617) 732-4870, 4875 to (617) 495-5100. This change became effective in February, 1985 and may be used to contact the Claims Department, Loss Control, Underwriting and Safety Engineering.

JACK GRINOVICH & ASSOCIATES, INCORPORATED

MEDICAL PERSONNEL RESOURCE CONSULTANTS
7300 NORTHWEST TWENTY-THIRD STREET BETHANY, OKLAHOMA 73008 (405) 789-4563

March 21, 1986

To: Physician Anesthesiologists Members- Department of Anesthesia

We are aware of the turmoil many physicians in Massachusetts are experiencing because of increasing malpractice rates and legislated caps on your earning ability.

We are recruiters and deal only with the specialty of Anesthesia. We would be glad to provide, on a confidential basis, information on positions we are currently recruiting for in various locations around the United States.

These positions range from large hospital groups, with and without teaching responsibilities to smaller groups and solo fee for service practices. Communities extend from metro to rural. Incomes may be salaried with benefits or substantial six figure fee for service practices.

It is not our intention to disrupt a department rather we want to assist an MDA who may be interested in exploring new practice opportunities. We can assist in arranging phone and on site interviews, confidentially of course.

For additional information contact:

Jack Grinovich
7300 NW 23rd Street, Suite 206
Bethany, OK 73008
405-789-4563

P.S. Conversely, should your department need temporary or interim Anesthesia personnel, perhaps we can meet that need from our pool of locum tenens MDAs and CRNAs.

QUESTIONS FOR DR. PIERCE FROM SENATOR HATCH

1. I understand in an interview with my staff you stated that the anesthesia profession has many similarities with the airline industry in terms of risk management procedures. Would you elaborate on that statement?

2. In your opinion, has the quality of risk management in your profession equaled or exceeded that of the airline industry?

3. You state that videotapes emphasizing risk management procedures in the use of anesthesia are being distributed by your organization. Would you briefly describe what these tapes demonstrate and to how many hospitals you are marketing them?

4. In your opinion, is the State of Massachusetts in danger of losing doctors and other health care professionals to other states because of the malpractice insurance crisis? If so, could you provide documentation for the record?

Response to Questions by Senator Hatch
By Ellison C. Pierce, Jr., M.D.

1. The specialty of anesthesia does have similarities with the airline industry in terms of risk management.

Both are equipment oriented, with the equipment subject to design error that can result in increased incidence of human error as well as functional failure that can be lessened by proper pre-use checks, preventive maintenance and repair. Both professions require education and training in overall principle as well as proper use of the equipment. As equipment design is altered, both require re-training and in-service education.

It is believed that population exposures are similar in anesthesia and the airline industry. Injured parties have no direct control over self-protection. Both are characterized by short periods of intense concentration, followed by longer periods requiring vigilance, monitoring and occasional moments of crisis where reflex actions, judgement and mechanical dexterity--intellectual crisis management skills--must be brought to bear for optimal results.

The difference is that when a life is lost in anesthesia, it is a single loss. In aviation, there are multiple deaths.

2. In my opinion, the quality of risk management in anesthesia has not equaled that of the airline industry. The reasons for this are unclear but are perhaps related to the publicity associated with one single aircraft accident. However, anesthesia is probably--within medicine--the specialty that has made the most dramatic efforts in medical risk management.

3. Six videotapes in the patient safety series have been completed.

1. Overview
2. Prevention of Disconnection in the Breathing Circuit
3. Anesthesia Machine Check-Out
4. For the Record: An Examination of Record-Keeping in Anesthesia
5. Mishap: Human Error in Anesthesia
6. On Trial: Adverse Outcomes in Anesthesia

Presently some 800 complete series have been sold to various individuals and hospitals. The cost of the series is $350.00 (significantly less than the actual production costs). Extensive efforts at marketing are under way.

The tapes forcefully address the most important safety issues in anesthesia. They are aimed at motivating the practitioner to take individual and general steps towards preventing anesthesia injury. The tapes are unprecedented in the subjects they address--dealing directly with specific issues in anesthesia management. They have been warmly and appreciatively received by anesthesiologists and it appears they are making an impact in raising the consciousness of clinicians.

4. In my view the Commonwealth of Massachusetts is in considerable danger of losing doctors to other states because of our malpractice insurance crisis. In no other state is it impossible to pass through the increased costs. Reimbursement for both Massachusetts Blue Shield and Medicare patients (by law) are limited to assignment levels with no balanced billing allowed. In most hospitals this makes up some two thirds of the patient population.

It is my impression that the actual departure of individuals to other states at present has been minimal but that a substantial exodus may be imminent. In anesthesia most residents training at the Harvard and other residency programs set up pracice in other states.

I enclose a copy of an advertisement I received recently inviting anesthesiologists to move out of Massachusetts.

Senator **Pell**. Mr. Salman.

Mr. **Salman**. Senator Pell, thank you for the opportunity to speak with you today.

Let me share some of my background. I am responsible for the risk management activities for the Sisters of Charity Health Care System, a large, Catholic, multihospital system based in Cincinnati, with hospitals and other health care operations in Colorado, New Mexico, Michigan, Ohio, and Kentucky.

In addition, the System also owns an insurance company which provides the insurance for the hospitals of the System. I operate that insurance company.

With 13 years 'experience in health care risk management, I was the first president of the American Society for Hospital Risk Management, and have served in numerous other leadership positions.

I recently coauthored and edited a handbook on health care risk management. In addition, I chair the Subcommittee on Malpractice Legislation of the Ohio State Bar Association.

I speak to you as someone who has been involved with the insurance industry during its previous cycles.

I commend the Senate on its legislation to address the problems that exist in today's environment. S. 1804 appears to have identified the areas that are necessary to both adequately provide for injured parties and to provide some relief from runaway jury verdicts leading to runaway settlements in medical malpractice claims.

If you look at the number of claims today and the dollar volume, the problem is real. It is not a problem contrived by insurance companies to increase their profits. Also, if you consider the number of medical malpractice insurers that are either in rehabilitation or insolvency under the various State insurance departments, the insureds of those companies who lose their coverage and their premiums are convinced that this is not a contrived problem.

This does not mean that part of the problem was not caused by insurance company management practices, but nonetheless, the problems as they exist today are indeed real.

I will focus my comments today on two critical area. They are risk management programs and disciplinary or recertification actions concerning practice patterns of health care professionals.

From my past experience, I see these two areas as being key to controlling insurance costs, but unless they are clearly defined in the legislation, they may be of no significant improvement.

Risk management in hospitals, as you may know, is a new and yet undefined discipline. In the health care industry, people are hired as risk managers who have widely varying educational and experiential backgrounds. It is typical to find in one hospital a retired fireman as risk manager, and in another, a former insurance broker or underwriter, and in yet another, a nurse physician or pharmacist. Many hospitals hire attorneys as risk managers.

In well over half the hospitals with such programs, the risk manager divides his or her time between risk management and other supervisory responsibilities. Very few of these people bring to the profession a formal base of knowledge in health care risk management. It is therefore easy to understand why the focus of the program in the hospital with the retired fireman is environmental safety and security; with the attorney, it is the hospital contracts and poorly written patient records; and with the nurse risk manager, it is medications, bedrails, and lost patient property.

Very few hospital risk management programs have put all of the necessary elements together into a comprehensive claims reduction/loss prevention program. Even the insurance companies who, in the last decade, required risk management programs, or provided premium reduction for hospitals having such programs, did not clearly define what risk management meant, or how the effectiveness of the risk management program would be measured.

The risk management requirement in S.1804 would be improved if minimum criteria are specified for risk management programs. There are national and State organizations of hospital risk managers who could provide assistance in defining risk manager qualifications, as well as establishing criteria to measure risk management programs.

A second aspect of this bill that I would like to address is the interdisciplinary review of patient care at the hospital level. Again, the bill addresses a necessary element to reducing liability exposure costs, but to be effective, it should provide enough protection for those who are asked to review the work of their peers to assure that this work is done effectively.

First of all, professionals reviewing other professionals' work must be assured that they are protected from civil liability for charges of defamation resulting form their review.

Second, reviewers are also concerned that their deliberations and decisions can be made available to plaintiffs through the discovery process, and so will be far less willing to question or criticize the care given. If they can be assured that their conclusions are not subject to discovery, they may be more candid and thus more effective.

Finally, the bill should also have provisions to limit the exposure to antitrust liabilities of health care providers who retrospectively review patient care. Many practitioners whose privileges have been limited or withdrawn througb peer review proceedings have brought suit, claiming that the motivation of the provider in curtailing privileges is to prevent competition and restrain trade. Those suits are not generally successful, but are extremely expensive to defend and if successful, actual damages may be tripled.

It becomes quite easy for each side to point fingers and say that the other side is responsible for the problems that exist in the insurance and health care industries. However, I think that finding a more permanent solution is going to require compromise by the health care industry, the insurance industry, the legal profession, as well as some assistance in the form of legislative relief.

The three items I mentioned earlier certainly will encourage organizations to participate in activities to help resolve the problems.

Thank you.

Senator PELL. Thank you very much, Mr. Salman.

[The prepared statement of Mr. Salman follows:]

Sisters of Charity
Health Care Systems, Inc.

STATEMENT OF

STEVEN L. SALMAN

SENIOR VICE PRESIDENT & CORPORATE COUNSEL

SISTERS OF CHARITY HEALTH CARE SYSTEMS, INC.

CINCINNATI, OHIO

ON

MEDICAL MALPRACTICE

AND

RISK MANAGEMENT

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

U.S. SENATE

May 7, 1986

Corporate Office: 345 Neeb Road • P.O. Box 38804 • Cincinnati, Ohio 45238-5198 • (513) 922-9775

Mr. Chairman and members of the Committee I would like to thank you for allowing me this opportunity to speak with you today concerning a subject of great importance to both the health care delivery system in this country and the patients that it serves.

I would like to present a brief synopsis of my background so you will have some idea of the frame of reference from which I am speaking today. I am responsible for the risk management activities for the Sisters of Charity Health Care Systems, Inc. a large Catholic multi hospital system based in Cincinnati with hospitals and other health care related operations in Colorado, New Mexico, Michigan, Ohio and Kentucky. In addition, the system also owns an insurance company which provides the insurance for the hospitals of the system. I operate that insurance company. In addition we are members of The Catholic Health Association of the United States, whose nationwide membership includes over 900 hospitals and nursing homes. In my 13 years in health care risk management, I was the first president of the American Society for Hospital Risk Management, a past president of the Ohio Association of Hospital Risk Managers, and am currently the president of the Cincinnati Chapter of the Risk and Insurance Management Society (RIMS). I recently co-authored and edited The Handbook of Healthcare Risk Management, published by Aspen Publications. In addition, I chair the Subcommittee on Malpractice Legislation of the Ohio State Bar Association. I speak to you as someone who has been involved with the insurance industry during its previous cycles.

I have also had considerable involvement in the reviewing of both state and federal legislation dealing with the area of medical malpractice, and I reviewed with particular interest, Senate Bill 1804.

I commend the efforts to develop legislation to address the problems that exist in today's environment. S.1804 appears to have identified the areas that are necessary to both adequately provide for injured parties and to provide some relief from run-away jury verdicts leading to run-away settlements in medical malpractice claims.

If you look at the number of claims today and the dollar volume, the problem is real; it is not a problem contrived by insurance companies to increase their profits.

Also, if you consider the number of medical malpractice insurers that are either in rehabilitation or insolvency under the various state insurance departments, the insureds of those companies who lose their coverage and their premiums are convinced that this is not a contrived problem. This does not mean that part of the problem was not caused by insurance company management practices, but nonetheless the problems as they exist today are indeed real for the healthcare industry, health care professionals and ultimately health care consumers.

Because of the time limitations in preparing this testimony, I have focused my comments on two critical areas; however, I plan to prepare a more detailed statement for the record.

The two areas I plan to talk about are risk management programs acceptable to the state's licensing body and disciplinary or recertification actions concerning practice patterns of healthcare professionals. From my past experience I see these two areas as being key to controlling insurance costs, but unless they are clearly defined in the legislation, there may be no significant improvement.

Risk management in hospitals, as you may know, is a new, and as yet, undefined, discipline. In the healthcare industry, people are hired as risk managers who have widely varying educational backgrounds and experience. It is typical to find, in one hospital, a retired fireman as risk manager; in other, a former insurance broker or underwriter, and in yet another, a nurse, doctor or pharmacist. Many hospitals hire attorneys as risk managers. In well over half the hospitals with such programs, the risk manager divides his or her time between risk management and other supervisory responsibilities. Very few of these people bring to the profession a formal base of knowledge in healthcare risk management. It is, therefore, easy to understand why the focus of the program in the hospital with the retired fireman risk manager is environmental safety and security, with the attorney risk manager, it is hospital contracts and poorly written patient records, and with the nurse risk manager it is medications, bed rails, and lost patient property. Very few hospital risk management programs have put all these necessary elements together into a comprehensive claims reduction, loss prevention program. Even the insurance companies who, in the last decade, required risk management programs of their insured hospitals or provided a premium reduction for hospitals having such programs, did not clearly define what risk management meant or how the effectiveness of the risk management program would be measured.

The risk management requirement in S.1804 will better provide the assurances that were intended if minimum criteria are specified for risk management programs. There are national as well as state organizations of hospital risk managers who could provide assistance in defining basic risk manager qualifications as well as establishing criteria by which successful risk management programs in hospitals can be measured.

A second aspect of this bill that I would like to address is the interdisciplinary review of patient care. Again, the bill addresses a necessary element to reducing liability exposure costs, but to be effective, it should provide enough protection for those who are asked to review the work of their peers to assure that this work is done effectively.

1. Professionals reviewing other professionals' work must be assured that they will be protected from civil liability for charges of defamation resulting from their review. Without this protection, they will, understandably, be far less willing to undertake the peer review activity.
2. They are also concerned that their deliberations and decisions can be made available to plaintiffs through the discovery process, and so will be far less willing to question or criticize the care given. If, on the other hand, they can be assured that their conclusions are not subject to discovery, they may be more candid, and thus far more effective.
3. The bill should also have provisions to limit the exposure to antitrust liability of healthcare providers who retrospectively review patient care. Many practioners whose privileges have been limited or withdrawn through peer review proceedings have brought suit claiming that the motivation of the provider in curtailing privileges is to prevent competition and to restrain trade. These suits are not generally successful, but they are extremely expensive to defend and, if successful, actual damages are tripled. Health care providers are reluctant to run the risk of antitrust's treble damages.

It becomes quite easy for each side to point fingers and say that the other side is responsible for the problems that exist in the insurance and healthcare industries. However, I think that finding a more permanent solution is going to require compromise by the healthcare industry, the insurance industry, the legal profession, as well as some assistance in the form of legislative relief, not only in the size of claims but to facilitate a more effective means for internal policing. The three items mentioned earlier certainly will go a long way in encouraging organizations to participate in activities that will help resolve the problem.

Thank you Mr. Chairman for the opportunity to appear before you and the Committee today. This concludes my prepared remarks. I will be happy to answer any questions.

Senator PELL. Dr. Pierce, I believe your profession of anesthesiology is one of those where the premiums are very high.

Dr. PIERCE. Anesthesia is about two-thirds up the ladder. We are not as high as the neurosurgeons and the obstetricians, but we are not as low as the general practitioner.

Senator PELL. To ask you a personal question, what is your own specific premium?

Dr. PIERCE. Well, in the Harvard System last year, we paid almost $15,000 per physician. Through risk management and other interests, I think, at the Harvard hospitals, that I started 2 or 3 years ago, we have managed, I think, to decrease the number of claims, and therefore we have been moved down one rung on the ladder.

So, although the overall premiums in the insurance company went up 40-some-odd percent this year, we stayed about even, because were moving down a rung.

So I expect to pay this year about $15,000.

A physician, however, in the Stat, Dr. Rockett handed out a sheet this morning that points out that if the suggestions come to fruition as requested by the JUA, anesthesiologists for 1986–87 will be $70,000 which, in many instances, is more than 50, 60, 70 percent of their net income in Massachusetts.

Senator PELL. Thank yo verv much.

I would ask Counsel, Mr. Ryan, if there is anything further?

Mr. RYAN. No, there is not, Senator. Thank you.

[Additional material supplied for the record follows:]

Medical Group Management Association Founded 1926
Executive Office

STATEMENT OF THE MEDICAL GROUP MANAGEMENT ASSOCIATION

TO THE COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON

THE MEDICAL PROFESSIONAL LIABILITY CRISIS
MAY 9, 1986

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Center for Research in Ambulatory Health Care Administration

STATEMENT OF THE MEDICAL GROUP MANAGEMENT ASSOCIATION

TO THE COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON

THE MEDICAL PROFESSIONAL LIABILITY CRISIS
MAY 9, 1986

The Medical Group Management Association (MGMA) is a national professional association of more than 2,900 medical group practices, representing both single and multi-specialty groups. MGMA, which is headquartered in Denver, is the oldest and largest association of medical group practices and has been in existence since 1926. Our member medical groups include approximately 65,000 physicians nationwide.

The Medical Group Management Association would like to take this opportunity to express its support for the recent activity in both houses of Congress directed toward alleviating the current medical professional liability crisis. We would also like to express support for the principles outlined in S.1804, the "Federal Incentives for State Healthcare Professional Liability Reform Act," which was introduced by Senator Orrin G. Hatch (R-UT) in October, 1985.

Like other healthcare professionals, MGMA's members have experienced significant difficulty in dealing with the issue of professional liability. The rapid and unpredictable increase in insurance premium costs in particular makes the management of medical groups extremely complex. For this reason, it is not surprising that in a recent survey of insurance needs MGMA members rated the availability and expense of professional liability insurance as their number one insurance problem. There is presently no indication that problems related to the availability and expense of professional liability insurance will subside any time soon.

As the number of suits and size of awards have risen, the cost of premiums has increased, and as insurance has become more difficult to obtain, many physicians have chosen to withdraw from high-risk specialties, have taken early retirement, or have found it necessary to reduce the number of "high-risk" patients they serve. Other physicians have chosen to prescribe more tests, schedule more office visits, or take other precautionary measures in order to decrease their risk of liability, ultimately increasing consumer and government costs.

Some medical specialties and many states and geographic areas have been particularly hard hit by the malpractice crisis. In a recent survey conducted by the California Medical Association, 32 percent of the obstetricians responding to the survey reported that they had reduced or were considering reducing the number of deliveries they performed, and more than 46 percent were reducing their highest risk caseload. Clearly, one result of the failure to deal with the continuing increase in suits and the rise in malpractice premiums will be a reduction in the access of some patients to certain types of medical care and an increase in the cost of that care for other patients.

The continuing increase in healthcare costs has been a major focus of government concern because of Medicare, Medicaid and other healthcare programs, and because controlling healthcare costs is one ingredient in efforts to reduce the federal deficit. Medical liability premiums and additional tests or procedures ordered as defensive measures in case of lawsuits contribute to increasing healthcare costs. Clearly, federal activity directed toward tort reform is an important part of the effort to reduce both the costs of providing healthcare and federal spending.

Since most states continue to experience difficulty, it is important that the federal government provide clear guidance and incentives so they can better deal with the complex issues related to professional liability. For this reason, we are pleased that S.1804 includes incentives to encourage the states to adopt needed reforms--reforms which would help maintain the delicate balance needed to guarantee access to quality care and a fair and just system of awards for victims, while at the same time controlling costs.

We are also supportive of several reforms included in this bill which have been documented through an actuarial study commissioned by the American Medical Association and by Rand Corporation research to account for significant reductions in healthcare costs. These reforms include placing limitations on non-economic damages; providing periodic rather than lump sum settlements; eliminating the collateral source rule; and limiting attorneys' fees according to the size of awards.

In conclusion, the Medical Group Management Association would like to express appreciation to the entire Committee for devoting its attention to this issue at hearings scheduled this spring, and we would be pleased to provide any additional information to the Committee members or staff in order to ensure a favorable resolution of this problem.

American
Dental
Association

ADA

1111 14th Street, N.W.
Suite 1200
Washington, D.C. 20005
(202) 898-2400

May 16, 1986

The Honorable Orrin Hatch
Chairman, Committee on Labor
and Public Resources
428 Senate Dirksen Office Building
Washington, D.C. 20510

Dear Senator Hatch:

I am writing to request that the enclosed statement be inserted into the record in connection with your hearings on the professional liability insurance crisis.

We realize the difficulties of accomodating so many organizations and groups who wish to testify on such matters. Quite frankly, we would still prefer to testify; however, for the present, the Association is submitting this statement to help inform the committee as to the dental proffession's liability concerns. If, for some reason, your committee changes its plans regarding oral testimony, we would be most pleased to select a knowledgeable dental leader to represent the Association at that time.

Thank you for your help on this vital legislative issue, and we look forward to working with you in support of S.1804 on similar legislations.

Sincerely,

Bill Owens

William H. Owens, Jr.
Director
Division of Congressional Relations

WHO/la

Enclosure

ADA American Dental Association

STATEMENT

OF THE

AMERICAN DENTAL ASSOCIATION

ON THE

MALPRACTICE CRISIS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

MAY 15, 1986

Washington Office 1111 14th Street NW Suite 1200 Washington DC 20005 (202) 898-2400

The American Dental Association appreciates this opportunity to present its views on the adverse impact of rapidly escalating costs and the potential lack of availability of professional liability coverage.

Mr. Chairman, we commend you for your leadership in holding these hearings as well as introducing needed legislation, S. 1804, to help meet the present liability crisis. In particular, the Association thanks you for expanding the original definition of health care practitioners in the draft bill to include dentists and other licensed health care professionals as well as physicians.

Today's dentists are just one segment of the public that has become gravely concerned about the present liability crisis. There is no doubt that dentists presently practicing in the United States are providing the best quality dental care services in the world due to ever improving technology and enhanced standards of training. And yet, instead of enjoying the opportunities to provide this kind of care, the dental profession is faced with an increasingly litigious society, patients' unrealistically enhanced expectations, and the ever growing apprehension of being sued with or without any justification.

As a result of these and many other factors the dental profession recently has experienced increases in the frequency of claims filed, and the amount of awards granted. Nearly ten out of every hundred dentists will have claims filed against them this year. Awards in dental liability access have increased five fold to almost $35,000 since 1978.

Last year dental liability insurance premiums increased over 300 percent. Three months ago such premiums were doubled for this year, thus combining for a 600 percent increase in 15 months. If no action is taken, it is expected that liability premiums will at least double every four or five years.

While premiums for a general dentist are still not exorbitant, many dental specialists, especially those who utilize general anesthesia in an outpatient setting, are beginning to pay amounts that dramatically affect how, where, and for how long they will continue to practice. For example, an oral surgeon in New York City who paid $150 for a million dollars of coverage in 1975, now pays $66,000 a year for the same coverage. In Florida, the average dentist utilizing anesthesia in an outpatient setting is paying $27,500, and in Dade and Broward Counties, the annual premium is $94,000.

This intolerable situation is already causing extreme hardship on members of the dental profession, especially the beginning dentist who must start his practice paying the same premium as his established counterparts. It is also beginning to affect older, experienced dentists who are at the peak of their practice years. Such dentists are now beginning to retire earlier in part due to the escalating insurance premiums and potential litigation.

Increased liability costs to health care practitioners have also driven up the costs of goods and services, including dental care, to consumers. Most important, the liability crisis has made dentists who are adversely affected to practice defensively, which has dramatically increased the nation's health care bill.

The dental profession has not only been faced with alarming increases in liability insurance premium rates, but also a contracting marketplace and the potential fear of non-availability of liability coverage at any price.

In New York State alone, in 1985, one malpractice carrier was bankrupted. One was forced into reorganization. One is under attack by the attorney general of the state for illegally marketing to the dental profession. One has withdrawn, and two have declared moratoriums on new business. Thus, the dentists in New York are largely left with one major carrier willing to offer dentists a program of liability insurance.

Recently, in West Virginia, the possibility of not having any available professional liability insurance has become a stark reality. Virtually all health professionals and hospitals in the state will be without coverage by the first week in June due to cancellation of policies, unless by the end of May the courts or the legislature intervene to avert this "crisis".

Mr. Chairman, without question the present litigation system is in need of major reform. Preliminary data from the Rand Corporation demonstrates that there certainly is a liability "crisis" particularly with respect to complex product liability and malpractice cases. However, we would recommend across the board tort reform that would not only resolve many aspects of the pending liability problem in general, but also would alleviate potential vulnerability to constitutional challenge on reforms limited only to health professional liability.

Additionally we would recommend that the present mandated list of state tort reforms be lengthened, and become more flexible in that states may select certain reforms that would be more tailored to their particular situation. This optional nature would also overcome a threshold problem with respect to certain states being ineligible due to the fact that certain mandated reforms were already struck down as unconstitutional.

Mr. Chairman, the Association believes that the tort reforms set forth in S. 1804 will have a beneficial impact on the liability problem over the course of time. However, the Association would also recommend other reforms that would have potentially greater impact on reforming the system in a favorable manner.

First, there can be no doubt that the present litigation system is being clogged with a number of frivolous claims. To help limit a number of these unwarranted lawsuits, the Association would recommend the inclusion of two additional reforms in S. 1804 -- an affidavit or certificate of merit and adoption of a modified version of the English rule on litigation. The former reform would require that each liability claim be accompanied by an affidavit certified by two or more professional members of a state health care professional board or panel that would certify that the particular case was meritorious or at least worthy of being litigated in court.

The other recommendation to help alleviate frivolous claims has been held to be constitutional when properly constructed--a modified English rule on litigation which would require use of pre-trial arbitration as a means to reduce litigation without jeopardizing one's right to go to court. It would impose a requirement that if the plaintiff goes to court and loses or does not substantially improve his position over pre-trial arbitration, then he pays the litigation and defense attorney costs.

The most promising area for reform in the litigation area is the promotion of alternative dispute resolution mechanisms (ADRs), such as arbitration, pretrial screening panels. This recommendation was strongly endorsed by the Department of Health, Education, and Welfare Malpractice Commission in 1973, and was recently reiterated in President Reagan's recommendations on liability reform.

At present 18 states have some form of ADR mechanism. Some of these have been effective and others have not. To be effective, it is important that such mechanisms are mandatory yet preserve one's right to due process and access to the courts. Preliminary data compiled on ADR mechanisms, e.g. mandatory, pretrial mediation system in federal courts of Michigan, demonstrates that such are effective in reducing the amount and costs of litigation.

Like the present litigation process, the insurance industry must also shoulder its share of the responsibility for the present liability crisis. Their failure to properly forecast economic conditions, to aggressively litigate cases, and to develop innovative approaches such as an experience rating of health care practitioners, has led the industry to merely passing on the costs of doing business rather than asserting leadership in trying to curtail rising premiums.

We strongly urge this committee and insurers to examine an experiental rating system for health care providers. It would consist of establishing various classes or categories of liability insurance rates based on one's record on malpractice settlements, judgments or arbitration awards, and on participation in ongoing risk management programs. For health care professionals with multiple judgments against them, there could be escalating increases in insurance rates. If such incidents continued to occur, this information could be forwarded to the state licensing board to investigate whether or not to reprimand the practitioner, or suspend or revoke his or her license. On the other hand, if practitioners maintained a good record and attended risk management programs on a periodic basis, then they could receive premium credits.

The insurance industry also should be encouraged through enhanced state regulation to make more public disclosures of their business, including the setting of liability insurance rates. If the insurance industry is not more forthcoming, then the states should raise the possibility of requiring insurance companies to write all types of insurance as a condition of doing any business in the state, including professional liability insurance.

We all realize that negligent practices do occur in dentistry as well as in other health professions or any other endeavor. Admittedly much more can be done by state disciplinary boards, peer review and risk management programs to insure quality of care and to prevent or at least minimize incidences of negligent practice.

While the Association has had an active program on peer review, we are presently re-dedicating ourselves to rendering the highest quality dental care services possible, and to urging state dental licensing boards to disciplining of negligent practices.

To demonstrate this commitment, our Association President Dr. Abraham Kobren has recently communicated with all constituent (state) and component (local) dental societies urging them to help strengthen the disciplinary functions of state licensing boards, peer review committees, and other mechanisms to assure quality of care to patients and to provide fair compensation for the victims of any negligent conduct. Dr. Kobren also suggested that legislation be sought at the federal and state levels that would provide limited immunity for such persons who serve on peer review committees. A copy of Dr. Kobren's letter is attached for your information.

The Association appreciates the opportunity to present its views, and we look forward to working with you and your staff in promoting liability reforms.

American
Dental
Association

211 East Chicago Avenue
Chicago, Illinois 60611
(312) 440-2500

ADA

March 26, 1986

Dr Bruce E Cunningham
Jacksonville Med Ctr
210 Henry Rd
Jacksonville, AL 36265

Dear Doctor Cunningham:

As you are aware, professional liability has become a significant problem not only for members of the Association, but also for our patients, indeed for society itself. During the past year many of you have asked me what the Association is doing to help us with the liability crisis that is now confronting us.

I want to assure you that the Association is actively working on the liability problem for you. Attached is a synopsis of the numerous Association initiatives undertaken in response to this burgeoning crisis.

The Association is responding to this complex problem at various levels, and in many forums. However, most important, we need your help at the state and local levels. We must remember that in professional liability, as in dentistry, prevention is the key. Risk management, loss prevention, and peer review must remain the mainstays of dental practice.

As we all know, it is never easy to review the possible misconduct of a colleague. However, today it is essential if the dental profession is to reduce liability costs, maintain the quality of care and retain the public's confidence.

Today, I personally urge you to re-dedicate yourself to working with the members of your dental society to maintain the high quality of dental care by supporting and participating in risk management and peer review activities, and by strengthening the disciplinary functions of your state licensing boards.

Please join the efforts of the Association in meeting the challenges of the liability problem. We, all of us together, are the American Dental Association. Your input and support is needed if we are to resolve this liability crisis for both the dental profession and the public it serves. As always, I would appreciate your thoughts and comments.

Sincerely,

Abraham Kobren

Abraham Kobren, M.S.,D.D.S.
President

AK:lmh

ASSOCIATION RESPONSES TO LIABILITY ISSUES

The Board of Trustees has established a comprehensive program to address the four principal aspects of the current problems. A Task Force on Professional Liability Issues coordinates Association efforts in these areas.

Insurance

The Council on Insurance has been involved in ongoing consultations with the CNA Insurance Companies, underwriter of the Professional Protector Plan, to assure the reasonableness of premium rates and coverages. The Council is also working with the carrier on the establishment of professional assessment committees and loss prevention programs.

The Association has developed a standby shelf insurance company so if market conditions dictate, we will have the capability to provide our members with liability coverage through this new company.

Loss Prevention

The Council on Insurance and Division of Communications have launched an extensive series of risk management programs, including loss prevention seminars, videotapes, publications and other activities.

The Council on Dental Care Programs assists constituent and component societies with their peer review programs, while the Council on Bylaws and Judicial Affairs and the Council on Dental Practice assist in the areas of professional ethics and impairment, respectively.

The Association has adopted policy pertaining to the training and credentialing of dentists who choose to administer general anesthesia and conscious sedation. Implementation of the policy is now underway.

Three councils of the Association have instituted programs to achieve acceptance of the uniform tooth numbering and radiograph mounting system by dental schools, dentists and third-party payers.

Dental schools are also being encouraged to include risk management as part of their curricula.

Legislation

The Association is actively supporting tort reform measures pending in Congress, including S.1804, Hatch (R-UT) and H.R. 3865, Lent (R-NY). The Association, represented by Dr. Leslie W. Seldin, testified before the House Ways and Means Committee on the causes of and potential solutions to the liability problem. Dr. Seldin reiterated the dental profession's commitment to strengthen peer review, disciplinary functions, and risk management activities as a means to maintain the high quality of dental care and to reduce liability concerns.

The Association is assisting constituent and component societies with efforts for tort reform and strengthening peer review. The Association's Department of State Government Affairs has provided assistance in analyzing proposed reforms, drafting legislation, preparing testimony, and sharing information from other states.

The Association filed a friend-of-the-court brief in the Illinois Supreme Court urging that a recently enacted liability reform statute be upheld and implemented. The outcome will have implications, as legal precedent, for many other states.

The Association has joined the American Tort Reform Association, which coordinates the activities of more than 200 organizations in seeking long-term solutions to our liability problems.

The Association also participates in the Health Policy Agenda for the American People. Initiated by the AMA, the program has representation from the major health professions and industry groups, and is addressing a number of significant issues, including liability.

Education and Communications

The Association continues to publish articles in the *ADA News* and *The Journal of the American Dental Association* to educate the profession and the public on liability issues and loss prevention. The Division of Communications provides information to the public media through news releases and responses to inquiries.

The Council on Journalism distributes monthly Dental Editors Kits which provide materials for constituent and component journals and newsletters. Included are issue papers, feature articles, and periodic loss prevention columns and news releases.

ORRIN G. HATCH, UTAH, CHAIRMAN

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United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510

March 3, 1986

Mr. David R. Clare
President
Johnson & Johnson
One Johnson & Johnson Plaza
New Brunswick, New Jersey 08933

Dear Mr. Clare:

On behalf of the members of the Labor and Human Resources Committee, I would like to thank you for appearing before the committee and presenting testimony during our recent hearing on OTC: Product Packaging Safety. We appreciate your candor in testimony and to questions. I also hope your Chairman, Mr. Burke, is recovering.

Hearings represent one very important way in which our representative democracy functions to provide lawmakers with all sides and perspectives on national policy. We appreciate your recognition of the importance of such hearings in the legislative process.

Again, your comments will be most valuable to our further consideration of this issue and we are grateful for your participation. Any further comments or recommendations are welcome and must be submitted by March 12, 1986.

Sincerely,

Orrin Hatch

Orrin G. Hatch
Chairman

AMERICAN COLLEGE OF NURSE-MIDWIVES

1522 K Street, N.W., Suite 1120, Washington, D.C. 20005 202/347-5445

May 6, 1986

Dear Senator Hatch:

We request that the enclosed packet of information be enclosed in the Congressional Record.

Thank you for your consideration of this request.

Sincerely,

Karen Ehrnman

Karen Ehrnman
Government Relations
Coordinator

AMERICAN COLLEGE OF NURSE-MIDWIVES

1522 K Street, N.W., Suite 1120, Washington, D.C. 20005 202/347-5445

FACT SHEET

Certified Nurse-Midwives Support S.2129/H.R.4301

The Problem:

The only way that certified nurse-midwives can obtain professional liability insurance is by forming an independent insurance company owned by nurse-midwives. ACNM's legal consultant has indicated that under the insurance laws of virtually all of the states, a new company could not write insurance unless it became licensed in each of these states.

This is a costly and time-consuming process that takes several years. Also, the capital requirements of a few of the states exceed the collective resources of nurse-midwives.

Temporary Insurance Coverage to End:

A survey of nurse-midwives across the U.S. reveals that the temporary insurance coverage under which many nurse-midwives are currently practicing will end this spring and early summer.

Therefore the new insurance company must be operational in all 50 states by summer.

The Solution:

S.2129--The Risk Retention Act Amendments of 1986.

H.R.4301--The Risk Retention Act Amendments of 1986.

Each bill amends the Product Liability Risk Rentention Act of 1981 to make it easier for businesses, associations, professionals, governmental entities and other organizations to form collective purchasing groups and self-insurance groups for general liability coverage.

CNMs Urge Congress to Act Quickly:

A bill of this type must be passed by the 99th Congress and signed by the President this spring. This is the only way to provide professional liability insurance to nurse-midwives in all states. This will allow them to continue to practice.

March 7, 1986

AMERICAN COLLEGE OF NURSE-MIDWIVES

1522 K Street, N.W., Suite 1120, Washington, D.C. 20005 202/347-5445

FACT SHEET: NURSE-MIDWIVES AND THE MALPRACTICE INSURANCE CRISIS

THE PROBLEM

The American College of Nurse-Midwives (ACNM) lost its blanket malpractice insurance coverage in mid-1985. General conditions in the insurance industry, most notably the sudden unavailability of reinsurance, were responsible. (The professional proficiency of ACNM's members was not a factor.) Suits have been filed against only six percent of them. Exhaustive efforts to obtain new insurance coverage have failed.

ACNM now sees a self-insurance plan as possibly the only solution to its insurance difficulties. Many legal and technical complications must first be overcome, however.

The organization urgently needs assistance from Congress to surmount these difficulties. (For details, see final item in the fact sheet.)

BACKGROUND

The American College of Nurse-Midwives is the professional organization for nationally certified nurse-midwives (CNMs) in the United States. Its 2,500 members represent close to 85 percent of the profession.

Members of the College are specialists in maternal and child health.

To become a Certified Nurse-Midwife, the candidate must complete a post graduate course of study and pass a national certification examination. Nurse-midwives must also meet state requirements for licensure and nurse-midwife practice.

CNMs work in clinical collaboration with physicians.

DETAILS OF THE CURRENT CRISIS

Since the early 1970s, ACNM had been able to obtain for its members group policies paying up to a million dollars a claim. Many hospitals required that amount as a condition for granting hospital privileges.

The last insurer was the Mutual Fire, Marine and Inland Insurance Company. It refused to renew the policy when it expired last July 1. The move was seen as part of a growing reluctance or refusal of insurance companies to write professional liability policies because risks outweigh the potential for profits.

During the past year, many ACNM members were able to keep practicing by purchasing insurance from one of two nursing groups whose policies did not exclude nurse-midwives. But this temporary coverage will begin to run out this spring. Insurances of both groups subsequently have written nurse-midwife exclusions into their policies.

Nurse-midwives must have somewhere to turn for liability coverage, to insure continuation of the profession.

THE SEARCH FOR NEW MALPRACTICE COVERAGE

After its last blanket policy was not renewed, ACNM applied to 17 other companies for policies. They represented most carriers in the U.S. who write professional liability insurance. All refused to write policies. Personal appeals to several insurance company presidents had no effect. Follow-up appeals to all 17 companies failed in many cases even to bring a reply.

ACNM members then were sent to talk with professional liability insurance companies in their states. They talked with governors, state legislators and state insurance commissioners.

Again the answer was no. Only one state -- New Jersey -- has been able to offer insurance from a private carrier.

Also at the state level, CNMs investigated joint underwriting authority (JUA), urging legislators to extend it to nurse-midwives. The effort was a success in many states, yet premiums have been too large in most cases, or the amount of insurance offered has been less than required.

After first rejecting the idea of self-insurance on the grounds of potential expense, the ACNM Board of Directors directed the staff to look into working with other groups to self-insure. This option proved not to be viable. Yet another idea, that of a joint federal private insurance arrangement, also proved unworkable.

With all this, ACNM was forced to come back to the idea of its own self-insurance plan. Consultants and attorneys are helping shape it, but help is needed from Congress as well. The lawmakers are being asked to:

LEGISLATIVE REQUIREMENTS

o Amend the 1981 Risk Retention Act. Currently, a new company could not write insurance unless it became licensed in every state -- a process of prohibitive trouble and expense. A legal change could make it possible to meet the requirements of one state, then write insurance in all states.

> S.2129 and HR.4301 The Risk Retention Act Amendments of 1986.
>
> Each bill amends the Product Liability Risk Retention Act of 1981 to make it easier for businesses, associations, professionals, governmental entities and other organizations to form collective purchasing groups and self-insurance groups for general liability coverage.

o This action must occur quickly in order for the new insurance to meet the needs of Certified Nurse-Midwives.

3/11/86

The New York Times

Founded in 1851

ADOLPH S. OCHS, *Publisher 1896-1935*
ARTHUR HAYS SULZBERGER, *Publisher 1935-1961*
ORVIL E. DRYFOOS, *Publisher 1961-1963*

4/14/86

Midwives and Other Untouchables

Nurse-midwives, who help women have babies in hospitals or in small "birth centers," know how to be resourceful in crisis. Now they face a crisis of insurance: an industry spooked by soaring losses on obstetricians refuses to protect midwives against malpractice claims. That seems especially unfair; unlike obstetricians, midwives are rarely sued. Ever resourceful, however, they propose to insure themselves through their association.

A bill before Congress would make that easier for all such stranded groups. While the cautions sounded by insurance regulators and other experts are worth noting, the legislation deserves support.

Federal action is necessary because differences in state regulations inhibit the do-it-yourself approach. If the midwives association sets up a company — a so-called risk retention group — it now would have to satisfy regulators of each state in which an insured member practices. In 1981, however, Congress allowed groups of product manufacturers to insure their members in all states so long as they met the requirements of a single state. Bills in Congress now would extend the law to virtually all business, government and professional groups.

Insurance agents and state regulators fear a "free for all" of organizations scrambling to set up shaky companies in states with lax regulation. They also worry about mismanagement by inexperienced groups. They point to the insolvencies of "bedpan mutuals," the intrastate self-insurance groups of doctors stripped of malpractice coverage.

Promoters of do-it-yourself insurance acknowledge the risks but say they have no choice. The law would relax rules only for insurance sold to group members, not the general public. It would buy a few years' time before changes in the insurance market and broader reforms of liability law again make midwives and other insurance untouchables attractive to private carriers.

A better way to extend do-it-yourself insurance might be for Washington to set national standards of management. But supporters of the legislation fear that would be perceived as a step toward nationalizing the insurance business, killing any chance for Administration support.

That leaves a choice between a flawed remedy and none at all. Can midwives skilled at delivering babies deliver themselves of a sound insurance company? With no other hope, they deserve the chance to try.

The New York Times

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4/7/86

How to Escape the Insurance Crisis

Along with oil and credit, American society runs on insurance. How to address the national crisis created by its sudden scarcity?

(A) Crack down on the lawyers who manipulate juries to win outlandish settlements — and fat contingency fees. (B) Crack down on the insurance industry, which seems unable to manage its cash flows responsibly. (C) Try to teach the public that enormous liability judgments are not cost-free. (D) All of the above.

The correct answer is (D), but the Reagan Administration glibly circles only (A). The recent report of its commission on the insurance crisis strains to absolve the industry while calling for stern measures to rein in a runaway legal system. All the more reason to praise a New York state commission on the crisis for taking a fuller measure of the industry problem. Its new report makes clear the need for innovative insurance regulation in tandem with legal reform.

•

For months, the public debate has focused on horror stories about apparent legal excesses — like the case in which a school's insurer had to compensate a burglar who injured himself falling through the school's skylight. The New York report forces attention to another factor, the volatile gyrations of the insurance business.

Liability insurers make money on premiums as well as on the investment of reserves held to cover eventual settlements. When interest rates were high, insurers cut premiums to attract business and more cash to invest. That ignited a fierce price war that persisted even after interest rates fell.

Then, as investment income declined, claims began to come in on the cut-rate policies, and insurers were in a bind: income down, payments up. Premiums rose abruptly and companies dropped riskier lines of insurance. The New York commission denounces "the industry's lemming-like abandonment of sound underwriting practices in pursuit of investment income, and its subsequent march into a sea of red ink."

But neither does the commission shed tears for the lawyers. Anyone who thinks insurers alone are the reason for the runup in liability costs should consider the persuasive example of New York City, which insures itself and so is immune to the industry's cash flow problems. Between 1978 and 1985, the city's liability claim payments jumped from $23 million to $118 million. Such increases reflect the willingness of lawyers to exploit the courts' expansion of liability and jurors' feelings that no one pays for liability awards against big institutions.

The commission, like the Federal study group, therefore endorses "tort reforms." It would limit awards for pain and suffering, and make parties only partially at fault liable only for partial damages. But it also calls for tougher regulation of insurance. The central proposals are for "flex rating" — restricting changes in premium rates to a fixed percentage — and for prohibitions against dropping lines of coverage.

Insurers and lawyers already heatedly debate the report, preparing for legislative battle. The battle itself can have broader potential usefulness. Ultimately, the crisis may only be relieved as the public learns how the insurance system works beyond the courtroom, how much we actually pay for those stupendous awards that now seem to fall like Lotto from the sky.

The right answer is still insurance reform *and* tort reform *and* public education: all of the above.

The Unavailability of
Professional Liability Insurance
for Certified Nurse-Midwives

United States Senate
Committee on Commerce, Science
and Transportation
March 20, 1986

Good afternoon. My name is Karen Ehrnman and I represent the American College of Nurse-Midwives. Nurse-midwives across America support S.2129. In addition, many of our hundred thousand or more clients are supportive of this bill on our behalf, as are large numbers of professional colleagues.

This testimony will describe why this bill is so very important to the future practice of nurse-midwifery in the United States. Briefly, since last summer the American College of Nurse-Midwives, the professional association for nationally certified nurse-midwives, has been unable to obtain a blanket insurance policy for its members. This denial of insurance was because of general conditions in the insurance industry and not because of our members excellent professional performance. Suits have been filed against only six percent of all nurse-midwives -- a number not considered high among medical professionals. Our earlier testimony before this committee (March 4, 1986) chronicles each step we took to try to obtain insurance of this type. We were unsuccessful.

Additionally, nurse-midwives went to the states to become included in joint underwriting associations (JUAs) which provide professional liability coverage for physicians, hospitals and other designated health care providers where traditional markets have declined. Although several state JUAs are actively covering nurse-midwives, these premiums are prohibitively expensive. For example, the proposed New York state premium is nearly $72,000. Nurse-midwives average salary is $25,000. At the state level, we have also spoken with almost all 50 state insurance commissioners. Although many of them have tried to help us, their hands have been tied. Only one state -- New Jersey -- has been able to provide insurance from a private company. It is clear that no insurance company wants to write professional liability insurance for nurse-midwives. (Again, I refer you to March 4, 1986 testimony on reasons given by insurers for not wanting this business.)

Therefore, our only option at this time is for nurse-midwives to band together to form their own independent insurance company. Again, I stress, we see no choice. The process of systematically looking at each option available to us and eliminating those which were not workable has taken almost a full year. (We were officially notified last May that our policy would not be renewed on July 1, and we were apprised of this possibility earlier last spring.) During this year we were fortunate to find that many of our members could temporarily purchase insurance through two other nursing organizations. Since the insurers of both of these nursing groups have subsequently written into the policies an exclusion of nurse-midwives, there are NO companies at all writing this coverage at the present time.

From a survey of our membership, we know that this temporary coverage ends this spring and early summer. Therefore the new insurance company must be operational in all 50 states by summer. As you know, under the insurance laws of virtually all the states, a new company could not write insurance unless it became licensed in each of these states. This time consuming process could take several years. Again, we need to have the new company operational by summer.

S.2129, if passed by Congress and signed by the President, would facilitate this process. The bill would allow nurse-midwives to become licensed as an insurer in one state and then write insurance in all fifty states. This is the only way that we will be able to set up a company within the required time frame.

I would also like to take this opportunity to present our views on some proposed amendments to this bill under discussion this week.

Nurse-midwives have hired some of the very best technical insurance consultants and legal consultants to deal with this problem. The business plan is designed as a long-term commitment of nurse-midwives to this proposed company. The company will be owned by nurse-midwives. They will need to borrow possibly $6,000 to provide the necessary funds for premiums and capitalization. In addition, our risk management program will be strengthened. Only six percent of nurse-midwives have ever been named in a suit. Nurse-midwives participate in peer review and the American College of Nurse-Midwives both certifies and decertifies nurse-midwives. We intend to maintain this excellen record. This, in turn, will contribute to the financial stability of the company. The amounts of coverage, premium levels, capital requirements and other financial concerns have been analyzed by several actuaries. We believe that this is the proper manner to make these determinations. We believe that review of this information by one insurance commissioner is sufficient.

For our purposes, any additions to the bill that require discussion with all fifty state insurance commissioners ar superfluous and would represent an unnecessary burden. We have already spoken about this problem with each insurance commissioner and they, in turn, have confirmed what we knew. There are no insurance companies in the United States interested in writing a professional liability insurance policy for nurse-midwives. In addition, we would not want to be in a position that if offered insurance in a state, like New York for $72,000, that we would be unable to go forward with our own affordable insurance option.

Therefore, please pass S.2129 quickly. Help us get it passed by the full Senate and House of Representatives and help us form this insurance company by this summer.

I would be happy to answer any of your questions.

(STAFF WORKING DRAFT)
(APRIL 1, 1986)

99th CONGRESS
2d Session

S. 2129

IN THE SENATE OF THE UNITED STATES

February 28 (legislative day, February 24), 1986

Mr. KASTEN (for himself, Mr. DANFORTH, Mr. HOLLINGS, and Mr. ROCKEFELLER) introduced the following bill; which was read twice and referred to the Committee on Commerce, Science, and Transportation

April , 1986

Reported by Mr. DANFORTH

A BILL

To facilitate the ability of organizations to establish risk retention groups, to facilitate the ability of such organizations to purchase liability insurance on a group basis, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, . That this Act may be cited as the "Risk Retention Amendments of 1986".

Sec. 2. Section 1 of the Product Liability Risk Retention Act of 1981 (hereinafter referred to as "the Act") (15 U.S.C. 3901, note) is amended--

(1) by striking "Product"; and

(2) by striking "1981" and inserting in lieu thereof "1986".

Sec. 3. (a) Section 2(a) of the Act (15 U.S.C. 3901(a)) is amended--

(1) by striking paragraphs (1) and (3);

(2) by redesignating paragraph (2) as paragraph (1), and by redesignating paragraphs (4) through (6) as paragraphs (5) through (7), respectively;

(3) by inserting after paragraph (1), as so redesignated, the following:

"(2) 'liability insurance' means insurance covering an organization's legal liability for damages because of injuries to other persons, damage to their property, or other loss or damage to such other persons arising out of its business, trade, products, services (including professional services), premises, or operations, but does not include (A) personal risk insurance or (B) workers' compensation and employers' liability insurance;

"(3) 'organization' means any association, business, corporation (whether for-profit or not-for-profit), professional corporation or partnership (including individual practitioners with respect to their business or professional activities), church, hospital, school, university, or other institution, or a State or local government (or agency of such a government);

"(4) 'personal risk insurance' means homeowners, tenant, private passenger non-fleet automobile, mobile home, and other liability and casualty insurance primarily for personal, family or household needs rather than for business or professional needs;".

(4) in paragraph (5), as so redesignated--

(A) by striking ", Bermuda, or the Cayman Islands";

(B) in subparagraph (A), by striking "product liability or completed operations";

(C) by amending subparagraph (C) to read as follows:

"(C) which--

"(i) is chartered or licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any State; or "(ii) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and had certified to the insurance commissioner of at least one State that it satisfied the capitalization requirements of such State, except that any such group shall be considered to be a risk retention group only for the purpose of continuing to provide insurance to cover product liability or completed operations liability (as such terms were defined in this section as in effect before the date of enactment of the Risk Retention Amendments of 1986);"; and

(D) by amending subparagraph (E) to read as follows:

"(E) whose members, businesses or activities are similar or related with respect to the nature of their exposure to the risk of liability stemming from any business, trade, product, services, premises, or operations which are related, similar, or common to such members;"; and

(5) by amending paragraph (6), as so redesignated, to read as follows:

"(6)'purchasing group' means any group of persons--

"(A) which has as one of its purposes the purchase of liability insurance on a group basis; and

"(B) whose members, businesses or activities are similar or related with respect to the nature of their exposure to the risk of liability stemming from any business, trade, product, services, premises, or operations which are related, similar, or common to such members; and".

(b) Section 2(b) of the Act (15 U.S.C. 3901(b)) is amended--

(1) by striking "product liability and product"; and

(2) by inserting "and personal risk insurance" immediately after "insurance" the second time it appears.

(c) Section 2 of the Act (15 U.S.C. 3901) is further amended by adding at the end thereof the following:

"(c) Nothing in this Act shall be construed to exempt a group authorized under this Act from the policy form or coverage requirements of any State no-fault automobile insurance law.

"(d) The authority to offer or provide insurance under this Act is limited to liability insurance. This Act does not authorize a risk retention group or a purchasing group to provide coverage of any other line of insurance.".

Sec. 4. (a) Subsection (a)(1)(C) and (D) and subsection (b)(1) and (2) of section 3 of the Act (15 U.S.C. 3902(a)(1)(C) and (D) and (b)(1) and (2), respectively) are amended by striking "product liability or completed operations".

(b) Section 3(a)(1)(F) of the Act (15 U.S.C. 3902(a)(1)(G)) is amended--

(1) by striking "if--" and inserting in lieu thereof "if";

(2) by striking clause (i);

(3) by striking "(ii)";

(4) by striking "and" the second time it appears; and

(5) by adding at the end thereof the following: "any such examinations shall be coordinated to avoid duplication and unjustified repetition; and".

(c) Section 3(a)(1)(G) of the Act (15 U.S.C. 3902(a)(1)(G)) is amended by striking "the commissioner of the jurisdiction in which the group is chartered has failed to initiate such a proceeding after notice of" and inserting in lieu thereof "there has been".

(d) Section 3 of the Act (15 U.S.C. 3902) is amended by adding at the end thereof the following:

"(d) Nothing in this section shall be construed to affect the authority of any State to enjoin--

"(1) the solicitation or sale of insurance by a risk retention group to the public or any person who is not eligible for membership in such group;

"(2) false, deceptive or fraudulent acts or practices in the solicitation or sale of insurance to a member or a prospective member of a risk retention group, or other fraudulent conduct by any such group; or

"(3) the solicitation or sale of insurance by, or the operation of, a risk retention group that is in a hazardous financial condition.

"(e) Any risk retention group which intends to do business in a State other than the State in which it was chartered shall furnish notice of such intention to the insurance commissioner of such State. Such notice shall--

"(1) be furnished by certified mail;

"(2) identify the State in which such group was chartered;

"(3) state the number of members of such group in the State in which the risk retention group intends to do business; and

"(4) specify the lines and classifications of liability insurance which the risk retention group intends to offer.".

Sec. 5. (a) Section 4(b) of the Act (15 U.S.C. 3903(b)) is amended--

(1) in paragraph (1), by striking "product liability or completed operations liability insurance, and comprehensive general" and "which includes either of these coverages,"; and

(2) in paragraph (2), by striking "product liability or completed operations insurance, and comprehensive general".

(b) Section 4 of the Act (15 U.S.C. 3903) is amended by adding at the end thereof the following:

"(d) Nothing in this section shall be construed to affect the authority of any State to enjoin--

"(1) the solicitation or sale of insurance by an insurer, agent or broker to the public or any person who is not eligible for membership in such group;

"(2) false, deceptive or fraudulent acts or practices by an insurer, agent or broker in the solicitation or sale of insurance to a member or a prospective member of a purchasing group, or other fraudulent conduct by any such group or its insurer, agent or broker; or

"(3) the solicitation or sale of insurance to, or the operation of, a purchasing group underwritten by an insurer that is in a hazardous financial condition.".

Sec. 6. The Act (15 U.S.C. 3901 et seq.) is amended by adding at the end thereof the following:

"REQUIREMENTS OF CERTAIN INSURANCE POLICIES

"Sec. 6. Any insurance policy issued by a risk retention group shall state the following in 10-point type:

> "This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.".

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PROCEEDINGS AND DEBATES OF THE 99th CONGRESS, SECOND SESSION

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THE RISK RETENTION ACT AMENDMENTS OF 1986

HON. RON WYDEN

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Tuesday, March 4, 1986

Mr. WYDEN. Mr. Speaker, I rise today to introduce the Risk Retention Act Amendments of 1986. This measure, the companion to S. 2129, introduced by Senator KASTEN, will amend the Product Liability Risk Retention Act of 1981 to make it easier for businesses, professionals, associations, State and local governments, and other organizations to form collective purchasing and self-insurance groups for general liability coverage.

The increasing cost and scarcity of liability insurance has become a matter of national concern. Manufacturers, child care providers, municipal governments, hazardous waste disposers, nurse-midwives, schools, corporate directors and offices, truckers, physicians, architects, and other professionals find themselves facing a treacherous insurance market where coverage is either unavailable or unaffordable. Some have had their coverage canceled mid-policy, paid quadruple-digit increases in premiums, or have had to buy policies with reduced coverage and increased deductibles. For others, coverage is unavailable at any price.

Many of us view the current insurance crisis with various ideas on its causes, but I think it's safe to say that we are in general agreement that those groups unable to purchase affordable liability coverage should be given a chance to help themselves.

My proposal today is a first step to allow these distressed groups to join together to obtain insurance for their activities. There is no cost to the Federal Government in this measure, but it will save people money in the marketplace, either through actual savings on general liability insurance costs, or through the reduced costs that are handed down to consumers.

The Product Liability Risk Retention Act of 1981 authorized the creation of two different mechanisms to facilitate the ability of manufacturers, product sellers, and distributors to insure product liability risks. Risk retention groups are authorized to self-insure product liability risks. Collective purchasing groups are authorized to purchase comprehensive liability insurance on a group basis, if the policy includes coverage for product liability risks. The law facilitates the establishment of such groups by preempting, to the extent necessary, certain state laws which restrict the organization of group captive insurance companies and the sale of insurance on a group basis.

However, as it is written, the Risk Retention Act only addresses the problem of obtaining affordable product liability insurance. It helps only a few of the groups in need of commercial liability insurance at an affordable price. Furthermore, the act limits coverage to products and only allows for comprehensive general liability if the policy includes product liability risks. This excludes many other groups in our country that are in need of insurance.

The measure I am introducing today amends the Risk Retention Act to make it easier for others to form collective insurance groups for general liability insurance, by freeing them from conflicting requirements in each State in which they operate.

These amendments expand the definition of the groups to permit them to include those other groups seeking affordable general liability insurance. Businesses, professional groups, hospitals, schools, churches, or other institutions, and State and local governments could form risk retention and purchasing groups under this measure.

These groups would then be able to form purchasing or risk retention groups to obtain all types of general liability insurance, except for personal risk insurance, workers' compensation, and employers' liability insurance.

This proposal is not intended to solve all the problems associated with the current liability insurance crisis. It would only increase the ability of those needing general liability coverage to obtain favorable rates or to self insure as a part of a risk retention group. As such, this expansion of the Risk Retention Act should provide some immediate relief for those affected by the current liability insurance crisis, and it is my hope that my colleagues in the House will move quickly with our colleagues in the Senate to enact this legislation.

WYDENINS

HLC

99TH CONGRESS
2D SESSION

H. R. 4301

IN THE HOUSE OF REPRESENTATIVES

Mr. WYDEN introduced the following bill; which was referred to the Committee on ______________________

A BILL

To facilitate the ability of organizations to establish risk retention groups, to facilitate the ability of such organizations to purchase liability insurance on a group basis, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the ``Risk Retention Amendments of 1986´´.

TECHNICAL AMENDMENTS TO THE SHORT TITLE

SEC. 2. Section 1 of the Product Liability Risk Retention Act of 1981 (hereinafter in this Act referred to as ``the Act´´) (15 U.S.C. 3901, note) is amended--

(1) by striking out ``Product´´; and

(2) by striking out ``1981´´ and inserting in lieu thereof ``1986´´.

AMENDMENTS TO THE DEFINITIONS

SEC. 3. (a) Section 2(a) of the Act (15 U.S.C. 3901(a)) is amended--

(1) by striking out paragraphs (1) and (3);

(2) by redesignating paragraph (2) as paragraph (1), and by redesignating paragraphs (4) through (6) as paragraphs (5) through (7), respectively;

(3) by inserting after paragraph (1), as so redesignated, the following:

``(2) `liability insurance´ means insurance covering an organization´s legal liability for damages because of injuries to other persons, damage to their property, or other loss or damage arising out of its business, trade, products, services (including professional services), premises, or operations, but does not include (A) personal risk insurance or (B) workers´ compensation and employers' liability insurance;

``(3) `organization' means any association, business, corporation (whether for-profit or not-for-profit), professional corporation or partnership, church, hospital, school, university, or other institution, or a State or local government (or agency of such a government);

``(4) `personal risk insurance' means homeowners, tenant, private passenger non-fleet automobile, mobile home, and other liability and casualty insurance primarily for personal, family, or household needs rather than for business or professional needs;'';

(4) in paragraph (5), as so redesignated--

(A) by striking out ``, Bermuda, or the Cayman Islands'';

(B) in subparagraph (A), by striking out ``product liability or completed operations'';

(C) in subparagraph (C), by striking out all that follows ``State'' the first place it appears and inserting in lieu thereof ``; and'';

(D) in subparagraph (D), by striking out ``; and''; and inserting in lieu thereof ``;'' and

(E) by striking out subparagraph (E); and

(5) in paragraph (6), as so redesignated, by striking out ``product liability or completed operations''.

(b) Section 2(b) of the Act (15 U.S.C. 3901(b)) is amended--

(1) by striking out ``product liability and product''; and

(2) by inserting ``and personal risk insurance'' after ``insurance'' the second place it appears.

(c) Section 2 of the Act (15 U.S.C. 3901) is further amended by adding at the end thereof the following:

``(c) Nothing in this Act shall be construed to exempt a group authorized under this Act from the policy form or coverage requirements of any State no-fault automobile insurance law.

``(d) The authority to offer or provide insurance under this Act is limited to liability insurance. This Act does not authorize a risk retention group or a purchasing group to provide coverage of any other line of insurance.''.

CONFORMING AMENDMENTS

SEC. 4. (a) Subsections (a)(1)(C), (a)(1)(D), (b)(1), and (b)(2) of section 3 of the Act (15 U.S.C. 3902(a)(1)(C), (a)(1)(D), (b)(1), and (b)(2), respectively) are amended by striking out ``product liability or completed operations''.

(b) Section 4(b) of the Act (15 U.S.C. 3903(b)) is amended--

(1) in paragraph (1), by striking out ``product liability or completed operations liability insurance,

and comprehensive general liability insurance which includes either of these coverages,'' and inserting in lieu thereof ``liability insurance''; and

(2) in paragraph (2), by striking out ``product liability or completed operations insurance, and comprehensive general''.

(1) such projections and estimates as may be necessary to evaluate the progress of the program and to indicate the extent to which, and the pace at which, the objectives of the chapter are being achieved;

(2) an assessment of what problems exist and of the need for further research and development oriented toward the resolution of those problems;

(3) an assessment of the potential for commercialization of methane-fueled vehicles in various markets; and

(4) any recommendations which the Secretary may deem appropriate for legislation or administrative action which would further the purposes of this chapter or facilitate expanded commercial use of methane-fueled vehicles.

(Pub. L. 96-512, § 9, Dec. 12, 1980, 94 Stat. 2833.)

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in section 3803 of this title.

§ 3809. Authorization of appropriations; required funding

There are authorized to be appropriated to the Secretary for purposes of carrying out this chapter, not to exceed $3,000,000 for the fiscal year ending September 30, 1982, not less than one-half of which shall be for the purpose of making loans under section 3806(b) of this title; not to exceed $5,000,000 for the fiscal year ending September 30, 1983, not less than one-half of which shall be for the purpose of making loans under section 3806(b) of this title; not to exceed $5,000,000 for the fiscal year ending September 30, 1984, not less than one-half of which shall be for the purpose of making loans under section 3806(b) of this title; and such sums as may be necessary for the fiscal years ending September 30, 1985, and September 30, 1986. Any amount appropriated pursuant to this section shall remain available until expended.

(Pub. L. 96-512, § 10, Dec. 12, 1980, 94 Stat. 2833.)

§ 3810. Relationship to other laws

(a) Modification or waiver

Nothing in this chapter shall be construed as authorizing the Secretary or any other official with respect to any activity pursuant to this chapter to modify or waive the application of any Federal, State or local laws dealing with the production, transportation, storage, safety, use or pricing of methane.

(b) Promulgation of rules

Nothing in this chapter shall be construed as granting the Secretary or any other Federal official any authority to promulgate rules of general application to regulate the production, transportation, storage, safety, use or pricing of methane as a transportation fuel or vehicles which use methane as a transportation fuel.

(Pub. L. 96-512, § 11, Dec. 12, 1980, 94 Stat. 2833.)

CHAPTER 65—PRODUCT LIABILITY RISK RETENTION

Sec.
3901. Definitions.
3902. Risk retention groups.
  (a) Exemptions from State laws, rules, regulations, or orders.
  (b) Scope of exemptions.
  (c) Licensing of agents or brokers for risk retention groups.
3903. Purchasing groups.
  (a) Exemptions from State laws, rules, regulations, or orders.
  (b) Scope of exemptions.
  (c) licensing of agents or brokers for purchasing groups.
3904. Securities laws.
  (a) Ownership interest of members in risk retention groups.
  (b) Investment companies.
  (c) State blue sky laws.

§ 3901. Definitions

(a) As used in this chapter—

(1) "completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by—

(A) any person who performs that work; or

(B) any person who hires an independent contractor to perform that work;

but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability;

(2) "insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under applicable State or Federal law;

(3) "product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred;

(4) "risk retention group" means any corporation or other limited liability association taxable as a corporation, or as an insurance company, formed under the laws of any ~~State, Bermuda, or the Cayman Islands—~~

(A) whose primary activity consists of assuming, and spreading all, or any portion, of the product liability or completed operations liability risk exposure of its group members;

(B) which is organized for the primary purpose of conducting the activity described under subparagraph (A);

(C) which is chartered or licensed as an insurance company and authorized to engage in the business of insurance under the laws of any ~~State, or~~ which is so chartered or licensed and authorized ~~before Jan-~~

uary 1, 1985, under the laws of Bermuda or the Cayman Islands, except that any group so chartered or licensed and authorized under the laws of Bermuda or the Cayman Islands shall be considered to be a risk retention group only after it has certified to the insurance commissioner of at least one State that it satisfies the capitalization requirements of such State;

(D) which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person; and

(E) which is composed of member each of whose principal activity consists of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product or products;

(5) "purchasing group" means any group of persons which has as one of its purposes the purchase of product liability or completed operations liability insurance on a group basis; and

(6) "State" means any State of the United States or the District of Columbia.

(b) The definition of "product liability" in paragraph (4) of subsection (a) of this section shall not be construed to affect either the tort law or the law governing the interpretation of insurance contracts of any State.

(Pub. L. 97-45, § 2, Sept. 25, 1981, 95 Stat. 949.)

SHORT TITLE

Section 1 of Pub. L. 97-45 provided that: "This Act [enacting this chapter] may be cited as the 'Product Liability Risk Retention Act of 1981'."

§ 3902. Risk retention groups

(a) Exemptions from State laws, rules, regulations, or orders

Except as provided in this section, a risk retention group is exempt from any State law, rule, regulation, or order to the extent that such law, rule, regulation, or order would—

(1) make unlawful, or regulate, directly or indirectly, the operation of a risk retention group exept that the jurisdiction in which it is chartered may regulate the formation and operation of such a group and any State may require such a group to—

(A) comply with the unfair claim settlement practices law of the State;

(B) pay, on a nondiscriminatory basis, applicable premium and other taxes which are levied on admitted insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

(C) participate, on a nondiscriminatory basis, in any mechanism established or authorized under the law of the State for the equitable apportionment among insurers of product liability or completed operations liability insurance losses and expenses incurred on policies written through such mechanism;

(D) submit to the appropriate authority reports and other information required of licensed insurers under the laws of a State relating solely to product liability or completed operations liability insurance losses and expenses;

(E) register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process, and, upon request, furnish such commissioner a copy of any financial report submitted by the risk retention group to the commissioners of the chartering or licensing jurisdiction;

(F) submit to an examination by the State insurance commissioners in any State in which the group is doing business to determine the group's financial condition, if—

(i) the commissioner has reason to believe the risk retention group is in a financially impaired condition; and

(ii) the commissioner of the jurisdiction in which the group is chartered has not begun or has refused to initiate an examination of the group; and

(G) comply with a lawful order issued in a delinquency proceeding commenced by the State insurance commissioner if the commissioner of the jurisdiction in which the group is chartered has failed to initiate such a proceeding after notice of a finding of financial impairment under subparagraph (F) of this paragraph;

(2) require or permit a risk retention group to participate in any insurance insolvency guaranty association to which an insurer licensed in the State is required to belong;

(3) require any insurance policy issued to a risk retention group or any member of the group to be countersigned by an insurance agent or broker residing in that State; or

(4) otherwise, discriminate against a risk retention group or any of its members, except that nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

(b) Scope of exemptions

The exemptions specified in subsection (a) of this section apply to—

(1) product liability or completed operations liability insurance coverage provided by a risk retention group for—

(A) such group; or

(B) any person who is a member of such group;

(2) the sale of product liability or completed operations liability insurance coverage for a risk retention group; and

(3) the provision of insurance related services or management services for a risk retention group or any member of such group.

(c) Licensing of agents or brokers for risk retention groups

A State may require that a person acting, or offering to act, as an agent or broker for a risk retention group obtain a license from that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

(Pub. L. 97-45, § 3, Sept. 25, 1981, 95 Stat. 950.)

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99TH CONGRESS
2D SESSION

H. R. 4442

To amend the Product Liability Risk Retention Act of 1981 to facilitate the establishment of liability risk retention groups and purchasing groups.

IN THE HOUSE OF REPRESENTATIVES

MARCH 18, 1986

Mr. LENT introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend the Product Liability Risk Retention Act of 1981 to facilitate the establishment of liability risk retention groups and purchasing groups.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Liability Risk Retention Act of 1986."

SEC. 2. REFERENCES IN THE ACT.

Whenever in this Act an amendment is expressed in terms of an amendment to a section, the reference shall be deemed to be a reference to the Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 et seq.).

SEC. 3. AMENDMENTS TO THE DEFINITIONS.

Section 2(a) (15 U.S.C. 3901(a)) is amended—

(1) by striking out paragraphs (1) and (3);

(2) by redesignating paragraph (2) as paragraph (1);

(3) by inserting after paragraph (1), as so redesignated, the following paragraphs:

"(2) 'liability' means liability for damages because of injuries to any person, damage to property, or other loss or damage resulting from any business, trade, product, services (including professional services), premises, or operations, but does not include (A) personal risk liability, or (B) an employer's liability with respect to its employees;

"(3) 'personal risk liability' means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities, rather than from business or professional responsibilities;";

(4) in subparagraph (4)(A), by striking out "product liability or completed operations"; and

(5) in paragraph (5), by striking out "product liability or completed operations".

SEC. 4. REQUIREMENTS RELATING TO GROUPS.

(a) GROUP MEMBERS MUST BE SIMILARLY SITUATED.—(1) Section 2(a)(4)(E) (15 U.S.C. 3901(a)(4)(E)) is amended to read as follows:

"(E) whose members are similarly situated with respect to their exposure to the risk of liability stemming from any business, trade, product, services, premises, or operations common to such members;".

(2) Section 2(a)(5) is amended to read as follows:

"(5) 'purchasing group' means any group—

"(A) which has as one of its purposes the purchase of liability insurance on a group basis; and

"(B) whose members are similarly situated with respect to their exposure to the risk of liability stemming from any business, trade, product, services, premises, or operations common to such members;".

(b) RISK RETENTION GROUP MUST BE LICENSED AS LIABILITY INSURANCE COMPANY.—Section 2(a)(4)(C) is amended to read as follows:

"(C) which—

(i) is chartered or licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any State; or

(ii) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and had certified to the insurance commissioner of at least one State that it satisfied the capitalization requirements of such State, except that any such group shall be considered to be a risk retention group only for the purpose of continuing to provide insurance to cover product liability or completed operations liability (as such terms were defined in this section as in effect before the date of the enactment of the Liability Risk Retention Act of 1986);".

(c) RISK RETENTION GROUP MUST COMPLY WITH STATE TRADE PRACTICES LAW.—Section 3(a)(1) (15 U.S.C. 3902(a)(1)) is amended—

(1) by adding "and" at the end of subparagraph (G); and

(2) by adding at the end thereof the following new subparagraph:

"(H) comply with the trade practices law of the State;".

SEC. 5. EXAMINATION BY STATE INSURANCE COMMISSIONER.

Subparagraph (F) of section 3(a)(1) (15 U.S.C. 3902(a)(1)(F)) is amended by striking out "if—" and all that follows through the end of such subparagraph and inserting in lieu thereof the following: "if the commissioner of the jurisdiction in which the group is chartered has not begun or has refused to initiate an examination of the group;".

SEC. 6. LIMITATIONS.

The Act is amended by adding at the end thereof the following new section:

"LIMITATIONS

"SEC. 6 (a) Nothing in this Act shall be construed to exempt a group authorized under this Act from the policy form or coverage requirements of any State no-fault automobile insurance law.

"(b) The authority to offer or provide insurance under this Act is limited to liability insurance. This Act does not authorize a risk retention group or a purchasing group to provide coverage of any other line of insurance.".

SEC. 7. REQUIRED NOTICE IN ALL RISK RETENTION GROUP POLICIES.

Any insurance policy issued by a risk retention group shall state the following in 10-point boldface type:

"NOTICE

"This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group."

SEC. 8. TECHNICAL AND CONFORMING AMENDMENTS.

(a) IN THE SHORT TITLE.—Section 1 (15 U.S.C. 3901, note) is amended—

(1) by striking out "Product"; and

(2) by striking out "1981" and inserting in lieu thereof "1986".

(b) IN SECTION 2(b).—Section 2(b) (15 U.S.C. 3901(b)) is amended by striking out "product liability and product liability insurance" and inserting in lieu thereof "liability, personal risk liability, and insurance".

(c) IN SECTION 3.—Section 3 (15 U.S.C. 3902) is amended by striking out "product liability or completed operations" each place such term appears.

(d) IN SECTION 4(b).—Section 4(b) (15 U.S.C. 3903(b)) is amended—

(1) in paragraph (1), by striking out "product liability or completed operations liability insurance, and comprehensive general liability insurance which in-

cludes either of these coverages." and inserting in lieu thereof "liability insurance"; and

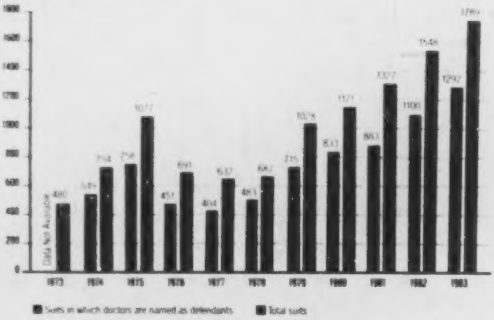
(2) in paragraph (2), by striking out "product liability or completed operations insurance, and comprehensive general".

○

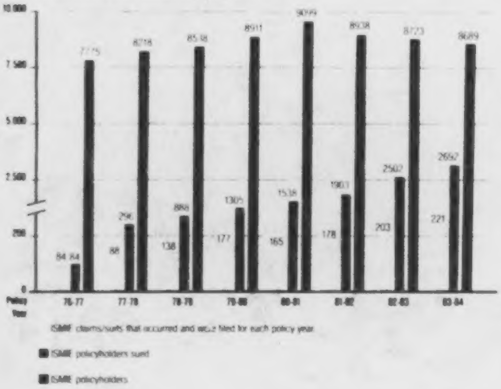
The Medical Malpractice Crisis In Illinois

MALPRACTICE
NOBODY WIN$...EVERYBODY PAY$

Health Care Related Suits Filed in Cook County
1973-1983



Comparison of ISMIE policyholders. ISMIE policyholders sued and ISMIE claims and suits that occurred and were filed for each policy year.



The Problem: Malpractice Suits Reach Crisis Proportions

We live in an increasingly litigious society. Malpractice litigation alone has exploded. According to the American Medical Association, medical malpractice lawsuits nationwide have tripled in the last five years.

In Illinois, the situation parallels the grim national picture. While the number of policyholders of the Illinois State Medical Inter-Insurance Exchange increased 12 per cent between the 1976-77 and the 1983-84 policy years, claims and suits occurring and filed during the same policy year rose 163 per cent over the seven-year period. During the same period, claims in Cook County rose 186 per cent.

Individual doctors in Illinois face incredible odds of being sued: about 46 per cent of the state's doctors have been sued at least once, and by age 45, the chances are 6 in 10 that each doctor in the state will have been sued.

A frightening proportion of the cases filed turn out to be without merit. The Illinois State Medical Inter-Insurance Exchange, a physician-owned carrier operated by the Illinois State Medical Society, reports that 80 per cent of all malpractice claims filed with it and closed since 1976 have involved no payment for damages. In those cases which have gone to trial, physicians have won 74 per cent. But even where physicians are not at fault, they still must defend themselves. And the ever increasing glut of cases with no merit is accompanied by a corresponding glut of legal defense fees.

For those suits resulting in no awards or where physicians are erroneously named in lawsuits, defense costs can be substantial. Illinois physicians paid $200 million for malpractice insurance protection in 1982. Nationally, physicians paid over $1.75 billion. The reasons for premium increases are clear from looking at how premium dollars are spent. The average costs of defending all claims and suits for the 1977-78 policy year were projected at slightly over $4,300; the average costs for the 1983-84 policy year have been projected at nearly $6,500.

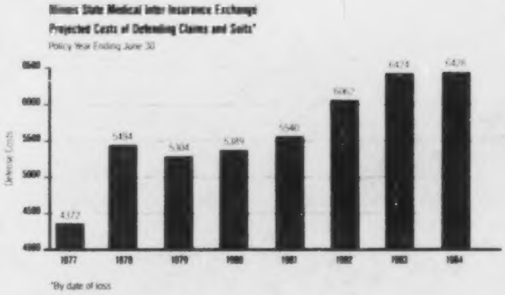
Legal expenses incurred by the Illinois State Medical Inter-Insurance Exchange (ISMIE) for physicians on claims closed with no payment to the plaintiff totaled eight and one half million dollars by mid-1984. These costs punished everyone: health care professionals, patients and society. We all paid.

High Awards: No Rewards For Anyone

Along with frivolous suits, high damage awards for medical malpractice have wrought havoc on the system, and awards continue to soar:

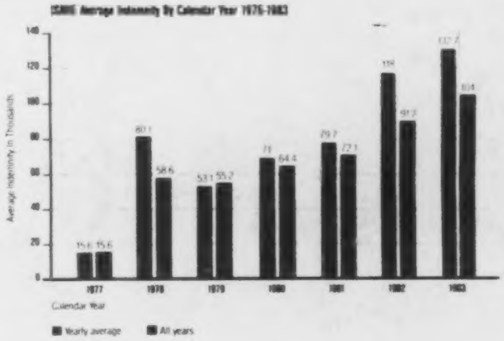
- Between 1981 and 1983, malpractice awards in the Chicago-area counties totaled $39.2 million;
- This is *double* the award figure for the previous *eleven* years;
- ISMIE's *average* award has also swelled from under $20,000 in 1977, to a 1983-84 all policy year average of $104,000, and in calendar year 1983 to over $132,000.

The accompanying charts illustrate the phenomenal growth in awards, indicating both increases in average awards from 1977 to the present and the number of awards exceeding $100,000 in the same period.

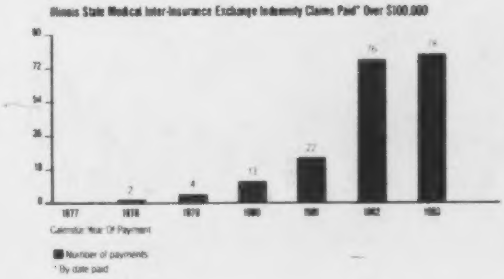


Illinois State Medical Inter Insurance Exchange
Projected Costs of Defending Claims and Suits*
Policy Year Ending June 30

*By date of loss



ISMIE Average Indemnity By Calendar Year 1976-1983



Illinois State Medical Inter-Insurance Exchange Indemnity Claims Paid* Over $100,000

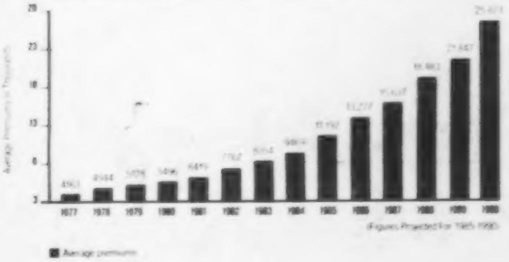
* By date paid

Why Awards Have Skyrocketed

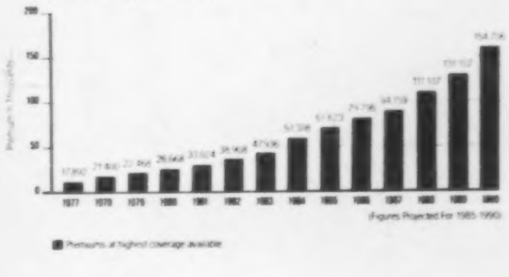
Employer paid insurance helps insulate the public from concern over large malpractice awards. Unfortunately, the public fails to realize an essential fact: it is *they* who are really paying the awards, since higher insurance premiums are spread among all of us in higher health care costs.

Media reporting also contributes to molding opinion about the appropriateness and attractiveness of filing suit: widespread publicity about multi million dollar awards makes large figures seem commonplace and acceptable. And juries have come to believe that huge awards are proper compensation.

Illinois State Medical Inter-Insurance Exchange Average Premiums (All Insureds)



Illinois State Medical Inter-Insurance Exchange Premiums (Based on Neurosurgeons in Chicago)



A Multifaceted Crisis: Visible And Hidden Effects

The immediate effects of this crisis are readily apparent. The rise in premiums for malpractice coverage and the need to raise *levels* of coverage have paralleled booms in malpractice awards and the costs of defending non meritorious claims. Eventually, these costs are passed on to patients as higher costs of medical care and higher health insurance premiums. But other effects, while less obvious and less direct, are no less crucial.

A Rocky Road For Insurance Carriers

For ISMIE, the largest malpractice insurance carrier in Illinois, covering nearly 60 per cent of the state's physicians, costs for premiums have risen continuously since its founding in 1976. Premiums jumped 127 per cent between 1976 and 1984. As the accompanying charts indicate, ISMIE estimates that premiums will increase another 173 per cent in the next six years if the present trend continues. High risk specialties may pay as much as $150,000 by 1990. Premiums average about $10,000, ranging up to $57,000 for neurosurgeons.

Premiums run particularly high for some specialties, especially in urban areas. Specialists in neurosurgery, orthopedics and obstetrics gynecology get the highest bills. The chart on the next page shows how specialization affects premium costs in Illinois.

Procedures for reporting and settling valid claims also have forced insurance companies to increase premiums. Claims which will be filed far in the future must be taken into account in calculating the costs for a particular policy year. Such claims usually are designated "incurred but not reported" and comprise an essential part of the accounting and rate making processes.

To understand "incurred but not reported" claims, think of a consumer's use of a charge card. A commitment for payment is "incurred" at the time of purchase but will not become payable until it is "reported" on the buyer's monthly charge account statement. Consumers would have considerable difficulty determining how much money to put aside to cover future debts if they had no control over who was using the card or when they would be responsible for paying the charges.

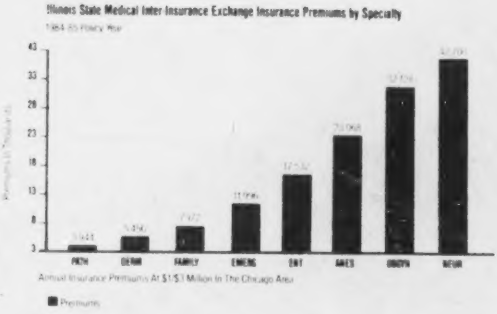
Compounding the delay in reporting claims are lengthy periods between filing and settlement. Because malpractice claims are so complicated and court dockets are so backlogged, the average period between the two events is three to four years. Consequently, only about *half* of the valid claims resulting from a particular year can be paid by ISMIE *within six years*. The Exchange anticipates that it actually will take *15 years* before all claims for a given year are paid. Meanwhile, inflation has a continuing impact, and the net effect of long reporting delays can be considerable.

Faced with these uncertainties and rising expenses, and resolved to stay solvent while continuing to indemnify physicians, insurance companies have had no choice but to increase premiums.

The Physician's Response

No business can continue to absorb such growing costs silently. Premiums for malpractice coverage have become too significant a cost to ignore, and physicians have little choice but to pass on some of those costs to patients.

Although the Illinois State Medical Society recently adopted a resolution supporting the AMA's recommendation that all physicians freeze their fees for a one-year period, beginning in April 1984, measures like these are at best a transitory remedy. Physicians are finding it difficult to keep costs in line when a substantial component of their business expense—malpractice insurance premiums—is wildly out of control.



Illinois State Medical Inter-Insurance Exchange Insurance Premiums by Specialty

1984-85 Policy Year

A study analyzing the effects of malpractice premiums on 1,245 physicians conducted by the American College of Obstetricians and Gynecologists demonstrates the severity of the issue. It found that one out of every five obstetricians includes more than 75 per cent of the increased costs in charges to patients. It further reported that over 50 per cent of all obstetricians and gynecologists increased fees two or more times in the last two years, with malpractice insurance cited as the major factor. But other factors contribute to rising costs even more so than doctors' insurance premiums.

Defensive Medicine: A No-Win Situation

As physicians become more sensitive to the risks of malpractice litigation, their practices must change to minimize them, often by using defensive tactics.

"Defensive medicine" involves additional tests, longer stays in hospitals, and consultations with specialists to confirm diagnosis and treatment.

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The magnitude of defensive medicine's impact is overwhelming. The American Medical Association estimates that between 30 and 40 percent of all physician ordered tests are defensive. Overall, the cost of defensive medicine in Illinois in 1982 was estimated at a staggering $725 million. In combination with the $200 million physicians paid for malpractice insurance, the bill for malpractice related medical expenses totaled almost $1 billion.

The Fear Factor: Limiting the Extent of Health Care

In addition to defensive medicine tactics, physicians have been forced to protect themselves by other methods which have even further negative effects on the optimum delivery of health care.

The increasing risk of lawsuits and burgeoning premiums have led some physicians to eliminate certain high risk procedures. The effects on one specialty — obstetrics-gynecology — are clear. An American College of Obstetricians and Gynecologists survey found the following:

- 33.5 percent of all obstetricians and gynecologists nationwide have decreased high risk procedures because of the malpractice situation, and
- Nationwide, 9.1 percent of all board certified specialists no longer deliver babies.

"Overall, the cost of defensive medicine in Illinois in 1982 was estimated at a staggering $725 million."

For all physicians, the situation is even more serious: an American Medical Association survey reports that about 35 percent of its membership has limited the types of cases they will treat.

Patients are the real losers when high risk procedures are avoided. Even patients willing to assume the risk that some procedures may result in an unfortunate outcome find it increasingly difficult to locate physicians who will perform these procedures.

Society: The Ultimate Payor

The public feels insulated from the tremendous increases in health care costs because many are covered by employer paid health insurance plans. Employers have seen their costs of providing employee health benefits rise 15 to 25 percent per year between 1980 and 1983. Faced with these annual increases, employers are searching for ways to stem these unpredictable costs. However, skyrocketing health care costs can't be kept in check if one component of the inflationary spiral — costs related to medical malpractice — is out of control.

Employers are investigating a number of methods to reduce their costs, but the net effect is clear: the gradual shifting of the health care cost burden to employees themselves.

Out of this necessity, employers are redesigning benefits, with such changes as:

- Increasing deductibles. In 1982, the typical deductible was $100, with only nine percent of all plans having a deductible exceeding $150; by 1984, 38 percent of plans carried deductibles of $150 or more.
- Increasing the employee's payment of health insurance costs. The previous standard was employee payment of 20 percent of the plan; today the standard is 30 percent.
- Eliminating coverage for some types of treatments and procedures.
- Eliminating coverage for spouses and dependents.

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Resolving The Crisis

Problems of this magnitude and complexity offer few easy solutions. Physicians are doing everything they can to reduce actual malpractice by maintaining a series of internal controls directed toward containing *incidence* of malpractice. What physicians cannot do is control the abuses of the legal system which have given rise to the crisis. To this end, the Illinois State Medical Society has proposed a legislative reform package addressing the problems of our malpractice system. Together, these programs will correct the crisis that affects all of us.

The internal control programs include:

Continuing Education Through Loss Prevention Seminars

Loss prevention seminars, conducted by physicians and attorneys with extensive experience in malpractice law and liability, focus on ways to improve the physician-patient relationship through better communications.

By the end of 1983, over 2,000 Illinois physicians had attended loss prevention seminars, with registration growing daily.

At the seminars, case studies of real and theoretical malpractice situations are followed by group discussions. Participating physicians are provided with information about the legal repercussions of substandard medical practice, potentially risky medical procedures, and settings that could negatively affect the physician's practice. Other programs use small group discussions to examine the unique problems of specialty practices.

The loss prevention seminars have had a tremendous effect on improving communications among physicians. Through the sharing of experiences and information, physicians are far better able to contain the incidence of actual malpractice.

But perhaps even more important is the emphasis the seminars place upon better communications between patients and physicians, through the following methods:

- encouraging dialogue that is both candid and understandable
- listening attentively to what patients say or ask and commenting or responding as precisely as possible
- telling patients as early as possible in the diagnostic treatment process what is wrong with them, what is the cause of their ailment, how long it will take to treat, and how much it will cost.

Peer Review of Fellow Physicians

Peer review, conducted by physicians, evaluates the quality and effectiveness of physician-ordered services and treatments. It covers medical audits and reviews medical practices, in-patient and extended care facility use, ambulatory care and claims. This process has always been and will continue to be an integral part of the medical profession.

Local Review: County medical societies review physician performance to clarify misunderstandings between patients and doctors, and to help practitioners improve their effectiveness. A committee of members reviews appropriate documents and may interview involved parties before its advisory decision is reached.

"Physicians are doing everything they can to reduce actual malpractice by maintaining a series of internal controls directed toward containing incidence of malpractice. What physicians cannot do is control the abuses of the legal system which have given rise to the crisis."

When the local committee finds a breach of medical ethics, it is referred to an Ethical Relations Committee. The Committee has the authority to recommend discipline, which may range from a reprimand to a revocation of society membership and privileges. Such breaches also trigger mandatory reports to the state's Medical Disciplinary Board.

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Hospital Peer Review: All Illinois hospitals must obtain accreditation from the Joint Committee on Accreditation of Hospitals (JCAH). One requirement for a hospital to receive JCAH accreditation is that its medical staff meet strict and specific standards regarding the monitoring and evaluation of the quality and appropriateness of patient care. The standards require, among other things, medical staff participation in continuing education activities and hospital peer review.

"Peer review has always been and will continue to be an integral part of the medical profession."

To assure the quality and competence of staff members, hospitals have a number of quality assurance programs, conducted by physicians on the medical staff, including:

- Reviewing credentials and experience of new applicants,
- Reviewing past performance of current members for reappointment,
- Reviewing appropriateness and use of hospital facilities by staff members,
- Reviewing the case for and quality of surgery,
- Ensuring that physicians accurately document services and findings, and
- Analyzing the reasons for patient deaths and complications.

Such federal programs as Medicare and Medicaid also require that staff or outside agencies review the need for and quality of medical care for their beneficiaries.

Hospitals that identify physicians as performing inadequate, incompetent or inappropriate care may place the physician under supervision or on probation, remove or restrict privileges to practice, or revoke membership on the medical staff. Again, any such hospital action must be reported for review by the state's Medical Disciplinary Board.

Impaired Physician Programs

Impaired physician programs are designed to help those suffering from mental or physical illnesses, addiction to drugs or alcohol, or senility. The ISMS Committee for the impaired physician helps confront physicians who need assistance and steers them toward appropriate counseling and treatment. The Committee also works to educate health care professionals about the problem of impairment and to establish impaired physician committees at every hospital to ensure early detection and treatment.

Medical Disciplinary Board

When peer review activities result in action against physicians, referrals and reports are made to the state's Medical Disciplinary Board. The Board, created by ISMS sponsored legislation in 1975, has the statutory authority to investigate complaints against physicians, conduct hearings on these allegations and recommend formal discipline ranging from reprimand to revocation of license.

A recent act proposed by ISMS expanded Board activities by requiring that licensed health care institutions report the following:

- Specialty and professional societies (including County Medical Societies) must report members who have had membership affected by disciplinary action,
- Public agencies must report physicians violating federal law,
- State's attorneys must report physicians found guilty of felonies, and
- Professional liability insurance companies must report physicians who have lost or settled malpractice suits.

Legislative Reform

The Illinois State Medical Society will be introducing a legislative package in early 1985, similar to that introduced in 1984, addressing inequities in the state's malpractice laws.

The proposals address today's two fundamental problems: skyrocketing jury awards and the increasing number of frivolous lawsuits.

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If adopted, the proposals would open the system to more equitable and timely resolution of claims without jeopardizing the right of medically injured patients to receive reasonable and swift compensation. Most significantly, the proposed legislation would restore the fairness which has disappeared because of the system's abuses.

Only by restoring the element of fairness can the system again function as it was intended: to provide swift and appropriate justice to those who have been truly injured because of negligence.

The proposals and their rationales are as follows:

Itemization of Awards

Proposal: Requires juries to itemize all elements of the award.

Rationale: Listing of specific dollar amounts awarded for items such as medical care, lost wages and earning capacity would force juries to be more disciplined in determining damages and discourage over-compensation, a factor in the high award phenomenon.

Itemization also would help identify erroneous awards not supported by the evidence, and would assist the court in ordering periodic payments, while still restoring the patient economically.

Structured Payments

Proposal: Provides that the court should arrange payment of awards greater than $50,000 over a specific time period rather than in one lump sum. In addition, award payments would stop if the injured party dies.

Rationale: Structured payments would guarantee that money would be available for the injured party's future needs and help prevent misuse of settlements by guardians.

Periodic payments would permit insurance companies to purchase annuities reducing short-term cost settlements without reducing benefits to the plaintiff. This would lessen the impact of large awards, which are spread among all of the insured individuals as a cost to other payors, but still protect the plaintiff's compensation.

Payments should stop with the death of the injured individual because the purpose of jury awards is to make the injured party as "whole" as possible, not provide windfalls to non-injured third parties.

Counter Actions for Malicious Prosecution

Proposal: Eases the burden of proof necessary to sustain suits by physicians for malicious prosecution.

Rationale: Under present law, a physician is required to prove special damages to be successful in a claim of malicious prosecution. Those special damages are defined as actual loss of liberty or property, interpreted to mean the physical taking of property or the jailing of an individual. This law, which has changed little since its adoption in 1848, does not recognize today's society.

As a result, fewer than 10 successful malicious prosecution actions have been brought in Illinois, the last in 1934.

The law sets a double standard for physicians. Doctors who have been negligent must bear responsibility for their mistakes, but they are effectively denied access to the courts to recover damages *they* sustain defending frivolous lawsuits. By eliminating the requirement of proving special damages, plaintiffs are on notice that filing unreasonable lawsuits may make them liable for their own "mistakes." Fairness dictates that since the doctor who makes a mistake that is unreasonable must pay the injured patient's expenses, the plaintiff who files unreasonably should pay the injured doctor's expenses.

Screening Panels

Proposal: Establishes a three person screening panel, consisting of a physician, lawyer and judge, to review the merits of malpractice cases before they go to trial. The panel's decision would not be binding. However, if either party chooses to challenge a unanimous decision by the panel and subsequently loses the suit, then that party must pay attorney's fees and court costs incurred by the successful party.

Rationale: Illinois courts today are clogged with numerous cases for which no awards are eventually granted. In the Chicago area counties in 1982, only 18 per cent of the cases tried resulted in any jury award.

Establishing an impartial screening panel to review cases could significantly reduce the number of frivolous lawsuits that end up in court.

In cases of actual malpractice, screening panels would encourage quicker settlements because physicians would have no incentive to fight a lawsuit unanimously decided against them at the screening level. By decreasing the number of frivolous suits filed, court dockets will be freed to hear a greater number of cases which have merit, and to resolve them more rapidly.

The results would be significant reductions in both defense costs and delays in settling cases of actual malpractice. Deserving plaintiffs would receive compensation more quickly.

Collateral Source Deductions

Proposal: Permits the reduction of jury awards by the amount the injured party has received from such collateral sources as medical insurance or worker's compensation.

Rationale: The purpose of tort law is to make injured parties "whole," not make them wealthy. Since juries are not aware of other payments, it is possible under the present system for an injured party to receive double compensation.

The courts have recognized that double compensation is not equitable: in some instances, Illinois law permits a credit for 50 per cent of the collateral source payments which have been received. By eliminating this double compensation, costs to society can be reduced without diminishing benefits to the plaintiff.

A Rand Corporation report concluded that mandatory award reductions reflecting collateral source payments have reduced malpractice awards by an estimated 18 per cent.

The ISMS proposal provides that awards could not be reduced if the injured party is required to repay collateral source payments or by the amount of premiums paid for insurance coverage under which collateral source payments are being received.

Limitations on Non-Economic Awards

Proposal: Places a $100,000 limit on awards for non-economic losses such as pain and suffering and loss of consortium.

Rationale: Under present law, there is no limit on awards to compensate for non-economic losses. As a result, this highly subjective part of the awards has been growing faster than the economic-based portion. While such intangibles as pain and suffering and loss of consortium do exist, they are all but impossible for a jury to translate into a monetary settlement and can be used to manipulate the emotions of the jury.

Limits for non-economic losses likely would reduce awards to a more reasonable level. A Rand Corporation study found that states with limits on non-economic awards in January, 1975, saw a 19 per cent decrease in awards by January, 1979.

The reforms, however, would not affect an injured party's right to full compensation for such economic losses as loss of earnings and costs of medical care.

Patient Award Guarantees

Proposal: Guarantees that plaintiffs will receive the majority of the award by establishing a sliding scale for attorneys' contingency fees.

Requires submission of contingency fee arrangements in writing to the court along with an affidavit stating that the attorney has not solicited the case unethically.

Rationale: Under the present system, some successful plaintiffs receive as little as 30 per cent of the award after deductions for attorneys' fees and trial-related expenses.

In a recent Illinois case, a plaintiff received a settlement of over $5 million. The plaintiff's attorney received a fee of $1.8 million and expenses of $46,000, even though there was no trial and only limited discovery. The ISMIE defense attorney received $24,411 in fees and $6,809 in expenses.

Patient award guarantees would ensure that awards are used for their intended purpose: to compensate the injured patient, not make the lawyer wealthy. Guarantees could help reduce the size of malpractice awards, since studies have shown that juries often increase damage awards to compensate for the anticipated attorney's share.

The requirement that attorneys submit statements and affidavits establishes as state law rules that have been adopted by the U.S. District Court for the Northern District of Illinois for personal injury actions. This requirement is aimed at making certain that attorneys' fees, just like damage awards, are reasonable based upon the value of the service and the needs of the plaintiff.

Early Dismissal of Uninvolved Physicians

Proposal: Permits early dismissal – through the filing of an affidavit denying all direct and indirect involvement – of physicians named in a lawsuit but not actually involved in the incident.

Rationale: Under the present system, lawsuits often take the "shotgun" approach, indiscriminately naming physicians with no involvement in the case.

In a recent case involving physicians, hospitals and a drug manufacturer, a malpractice insurer settled with the plaintiff's attorney in the amount of $35,000 to have a physician dismissed from the case. The physician had merely admitted the patient to the hospital for a prior stay, but was wholly uninvolved in the present action. Ultimately the patient won a verdict of $22 million, the vast majority of it paid by the drug company.

By allowing the court to dismiss physicians who have been erroneously named in the lawsuit, direct defense costs and indirect lost time from medical practices would be diminished.

However, the dismissal could be opposed or overturned if the plaintiff could show that a defendant was involved.

Proof of Economic Loss in Wrongful Death Cases

Proposal: Establishes a $25,000 limit on economic loss that doesn't have to be proved in cases of wrongful death.

Rationale: This proposal simply re-establishes a limit which has existed historically in Illinois law.

Recent Illinois case law provided for a substantial award for economic loss without any evidence supporting the existence of such a loss. This proposal establishes a rebuttable presumption that economic losses of $25,000 are reasonable. Either side could alter this level based upon specific evidence. However, in the absence of evidence, this proposal will establish a reasonable level which compensates the plaintiff without unfairly taxing the defendant.

Requiring proof of economic loss in excess of $25,000 – in such emotional cases as those involving dying newborns or stillbirths – can help ensure that awards will not exceed what is necessary to provide fair compensation and will prevent excessive awards not justified by the evidence.

Liability for Untrue Allegations

Proposal: Establishes the liability for plaintiffs or their attorneys who make untrue allegations without reasonable cause and permits the awarding of attorneys' fees and other costs incurred by defendants in challenging the false statements.

Rationale: Presently, a physician has almost no opportunity to recover defense costs relating to lawsuits based on untrue allegations made without reasonable cause.

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Your doctor does everything in his power to maintain you in good health. We entered the practice of medicine because we're concerned about your well being, and we do all we can to keep you well. □ It's because we're concerned about you that we want you to know about a problem related to health care. The problem is the cost of care nowadays—you know that costs are high, and they are getting higher. □ If you have insurance, maybe it doesn't seem as if costs are a problem. But they are. Everyone is paying more. □ A big part of what increases your health care bill is those costs associated with medical malpractice. We've done what we can to fight these costs, but we need more help. It will take special laws to fight a system that has gotten out of hand. Most important of all, we need your help to support passage of these laws. Under the current system, nobody wins, but everyone pays. □ This year, we are supporting new legislation that we think will help keep the cost of health care within everyone's reach. Please read on about the crisis in costs, and help us. You'll be helping your family, your friends, everyone that receives medical care in Illinois.

Malpractice Costs Everybody

Many factors contribute to the growing cost of medical care. Hospital costs are soaring, as are the prices of drugs and innovative procedures. But the fastest growing, most out of control elements in the spiral are those costs related to medical malpractice, and these costs *don't* improve the quality of care you receive.

Medical malpractice makes health care expensive because of the tremendous number of malpractice lawsuits. The Illinois State Medical Inter-Insurance Exchange (ISMIE), the physician owned carrier which insures 60 per cent of the state's doctors, reports that in its policy year 1983-84, 2,692 malpractice cases were filed against the doctors it insures. That compares rather unfavorably with the 296 cases filed in the 1977-78 policy year!

Of all cases resolved with ISMIE since 1976, 80 percent have been closed with no damages awarded to the plaintiff. Of those that have been tried, 74 per cent have been decided in favor of doctors. These figures indicate that most of the claims made against doctors are unfounded—they're lawsuits without merit. But even where doctors have done nothing wrong, they must defend themselves, and that gets expensive.

The suits without merit take advantage of our legal system. As a result, court dockets are clogged and patients with valid suits experience tremendous delays in being heard. The average time lag between filing suit and reaching trial in Illinois is three to four years. Clearly, the system needs improvement.

What This Means to You

The continuous threat of malpractice suits has caused subtle but dramatic changes in today's medical environment. Doctors have become extremely sensitive to the threat of a malpractice lawsuit, and have been forced to react defensively. We perform many tests and administer many procedures to protect ourselves from the possibility of a malpractice suit. We call this "defensive medicine," and the AMA recently estimated that between 30 and 40 per cent of all diagnostic costs are the result of defensive medicine. These costs are unproductive—patients rarely benefit from them but everybody ends up paying for them.

Health insurance, particularly when it's paid by your employer, tends to insulate you from this crisis. But eventually, the cost of providing health coverage may prove too expensive for your employer. Employers are searching for ways to cut their costs, with such options as:

- increasing amounts of deductibles
- limiting the types or extent of services that will be covered
- eliminating employer-paid coverage for spouses and family

In addition to defensive medicine costs, high malpractice awards and the cost of defending suits has caused physician malpractice insurance premiums to increase alarmingly. The combined costs of defensive medicine and high malpractice premiums added about $925 million to overall 1982 health care expenses in Illinois.

What Can Be Done

While there's actually very little incidence of malpractice, physicians are doing all they can to prevent the practice of bad medicine. But we need your help in solving the high costs of too many frivolous malpractice lawsuits.

Preventing the Problem of Actual Malpractice
Illinois physicians are attacking the problem of *actual malpractice* through various programs, within the medical profession:

- Physicians regularly review the performance of other physicians at their affiliated hospitals and in the county medical society.
- Physicians and lawyers conduct seminars which emphasize better physician-patient communications.
- Physicians offer assistance to other physicians suffering from mental or physical illnesses, addiction to drugs or alcohol, and senility and steer them toward appropriate treatment.
- The state's Medical Disciplinary Board created by physician-supported legislation in 1975, and funded totally through physician license fees—recently doubled to permit expanded Board activities—investigates complaints against physicians and recommends disciplinary action ranging from reprimand to revocation of license. Recent legislation strengthened the power of this Board.

Solving the Problem of Too Many Suits
The crisis caused by too many suits is a legal problem, not a medical problem. To resolve it, physicians support a series of legislative reforms which will be introduced to the state legislature in 1985. These reforms are directed toward protecting the rights of truly injured patients and improving certain parts of the system.

Our legislative reforms will preserve the constitutional rights of all citizens to have their day in court. If you are truly injured through physician negligence, you will find it easier to receive swift and just compensation for your injuries. Ultimately, our legal system will function better for everyone, and we'll be able to keep health care costs in line. But we can only attain our goals with your support. These reforms will do three things:

1. Help the truly injured to receive swift and just compensation:

- Provide long-term care for injured patients through periodic payments
- Guarantee that patients will receive the majority of the award by establishing a sliding scale for attorney's contingency fees

2. Help juries to make logical decisions about just compensation for injured patients:

- Requiring juries to itemize components of awards
- Permitting the jury award to be reduced by amounts received from other sources, such as worker's compensation or medical insurance
- Placing a limit on awards for non-economic losses, such as pain and suffering
- Requiring concrete proof for survivor claims in excess of $25,000 in wrongful death actions
- Eliminating assessment of punitive damages against doctors in malpractice awards
- Establishing standards for expert witnesses testifying in malpractice trials

3. Curb the abuses of the legal system

- Making it easier for physicians to recover legal costs they incur in defending frivolous lawsuits
- Establishing a screening panel to determine the validity of a malpractice claim before the suit goes to trial
- Permitting the early dismissal of physicians from a lawsuit in which they are named as defendants but were not involved in the incident
- Making plaintiffs or their attorneys accountable for untrue allegations without reasonable cause in malpractice actions

How You Can Help

We must convince the state legislature that this problem is an urgent one, and that it affects everyone. But, this isn't going to be easy. We must make the legislators understand that this crisis is far more widespread than a special interest issue. It affects the cost and availability of health care for all of us, and the situation will not improve by itself—only our legislature can do something about it. And our legislators will act only if they know you are concerned about the issues.

There are two ways you and I can show our concern:

- *Write or talk to our legislators.* Tell them how concerned we are about the cost of health care in Illinois, and the part malpractice related costs play in that. Urge them to vote for malpractice legislative reform by writing to your state legislator at the State Capitol, Springfield, Illinois 62706.
- *Write to our local paper with a similar message.* Items in the local media, particularly letters to the editor, are an extremely effective vehicle for influencing legislators' opinions.

By working together, we can ensure that the laws will treat everyone with fairness, and that the costs of high quality health care in Illinois will remain within everyone's reach.

STANLEY M. KIRSON, M.D., P.A.
8830 CAMERON STREET, SUITE 403
SILVER SPRING, MARYLAND 20910

(301) 585-5503

May 5, 1986

Mr. Jim Powell
Committee on Human and Labor
Resources
U. S. Senate
Washington, D.C. 20510

Dear Mr. Powell:

Enclosed are some further comments I have made on the malpractice issue over the recent years. These may give you some feeling for my capabilities for testifying before the subcommittee. In particular, I have a substantial familiarity with our arbitration panel system in Maryland which is unique. I was one of the original advocates and designers of that system and though it has its minor draw-backs, it has functioned well, overall.

Let me know if I can be of assistance even on such short notice. I believe I can contribute to the subcommittees deliberations.

Sincerely yours,

Stanley M Kirson

Stanley M. Kirson, M.D.

SMK:al
5 enclosures

Agenda Item #18

COUNCIL'S
AD HOC COMMITTEE
ON
TORT REFORM REPORT

MEDICAL and CHIRURGICAL FACULTY
of the STATE OF MARYLAND

1211 Cathedral Street Baltimore, Maryland 21201
Telephone 539-0872 (Area Code 301)

AD HOC COMMITTEE ON TORT REFORM

REPORT TO COUNCIL

The Ad Hoc Committee on Tort Reform began meeting in September, 1981 and met six times during its course of study of the medical malpractice problem and possible solutions in Maryland. This report will explore the areas studied by the committee and summarize the suggestions and conclusions of the committee.

HEALTH CLAIMS ARBITRATION IN MARYLAND

The Maryland method of Health Claims Arbitration is different from most other pre-court mechanisms operating in other states. Maryland has a mandatory, non-binding, non-judicial system using a 3-person panel composed of an attorney chairman, a health care provider and a consumer. Panel hearings are conducted using informal rules; the decision of the panel is presumed correct if the case is appealed to court. The panel determines if a cause for compensation exists and determines the amount of the award.

The committee consulted with Charles Channing, Esq., a defense attorney and with Walter Tabler, Esq., Director of the Health Claims Arbitration Office. Mr. Channing told the committee that, in his experience, an average panel hearing lasts 3-5 days, with the time for discovery and preparing a case the same as for a jury trial. Costs are normally assessed against the winners. He found three major problems with the present system: (1) poor calibre of panel members including inexperienced attorneys; (2) jurisdictional problems in the D.C. metro area where the provider is in one area and the hospital in another; (3) the inability to include outside entities such as pharmacies, medical device manufactureres and drug manufacturers.

Mr. Tabler reported that his office is current with its workload. He had two suggestions for improvement. First, he would like to see the panel treated the same as a jury so the lay panelist could receive compensation for time lost from work. Second, he would impose sanctions for failure to meet the deadlines established by the legislature with regard to completing panel work. Mr. Tabler submitted statistics to the committee as of December 31, 1981, including a list of health care providers by specialty, geographical location of available panelist and an overall summary of all cases filed on a year by year basis. The statistics are attached in Appendix I.

To assist in reaching its conclusions, the committee surveyed states using some form of arbitration or pre-trial screening. Six states replied to the questionnaire, and results are attached in Appendix II.

Two questionnaires to gather data about health claims arbitration in Maryland were circulated. Attorneys who had handled cases for the Medical Mutual Liability Insurance Society responded to 19 questions about the system and the results are listed in Appendix III. Physician members of the Faculty responded to an inquiry about health claims arbitration and those results are listed in Appendix IV.

Health claims arbitatration has been supported by the physicians of Maryland since its inception. The system has withstood numerous court challenges, the most recent of which was decided in late May. The committee agreed that arbitration application to liability issues was the most difficult area of committee study. John King, Med-Chi Counsel and member of the committee expressed his view that the present HCA system was not working well. Although some legal and medical authorities support the HCA concept as a judicial alternative, the committee identified a number of problems with the present Maryland system.

1. Excessive delays should be reduced to a reasonable time.

2. Panel chairmen are often inexperienced causing inconsistency among critera used by panels in deciding cases.

3. Insurance costs are increased by appealed cases and by frequent cost assessments by the panel against the defendant physicians.

4. There remains a tendency by panel chairmen to allow either side to delay on procedural grounds or to prolong panel hearings. Lay and physician members are thereby disillusioned and may become unwilling to serve.

During the 1982 legislative year, Medical Mutual attempted to make some changes in the law dealing with health claims arbitration. They submitted four proposals to the General Assembly, which were accepted in principle by this committee; they were: (1) Assessment of arbitration costs awarded in favor of the prevailing party in a suit; (2) Requirement for physicians to have 6 hours of CME in professional liability prevention; (3) Requiring a party rejecting the amount of damages to also reject the determination of liability and (4) Permitting the arbitration panel to approve legal fees if in dispute or in excess of $200,000. All four failed.

EXPERT WITNESS

The committee had extensive discussion about expert witnesses. The Faculty has introduced legislation in Maryland in this regard without success. Some bills have dealt with the qualifications in terms of practice and training for serving as an expert witness; others have limited geographic requirements. The last bill, introduced in 1980, limited an expert witness to one who practices in the United States.

The idea of local or national pools of expert witnesses that could be made available to both plaintiffs and defendants was discussed, but with the quick conclusion that this method would do nothing to assist physicians.

CAP ON AWARDS (Limitations on Recovery)

This refers to the establishment of a maximum ceiling on the amount of damages that may be recovered in medical malpractice cases. Of the 13 states that enacted some form of legislation in this area, 4 have discontinued the legislation either by court determined insufficiency or through legislative repeal. The committee looked at the statute as it exists in Indiana, the only Cap on Award statute found to be constitutional. The total recovery from any hospital and/or group providers is $500,000 with the liability against any single provider no more than $100,000. Attorneys fees are restricted to 15% unless other mutually statisfactory arrangements, on a per diem basis, are made between the plaintiff and the attorney. There is no clear constitutional limitation in Maryland to this reform.

CATASTROPHIC FUND

The committee examined the concept of a catastrophic fund as exists in Pennsylvania. These funds are also referred to as "Excess Recovery Funds" or "Patient Compensation Funds". Such a fund is a governmentally operated mechanism established to pay that portion of any judgment or settlement against a health care provider which is in excess of a statutorily designated amount. Excess recovery funds are generally supplied through an annual surcharge assessed against health care providers, with such a surcharge often being a specified percentage of the provider's annual insurance premium.

To examine this mechanism closely, the committee invited Mr. Harry Stefchak, Chief Counsel for the Medical Professional Liability Catastrophe Loss Fund of Pennsylvania to discuss the Pennsylvania experience.

A summary of the Pennsylvania fund, as well as information about other state CAT funds as received from a questionnaire is listed in Appendix V. Some specific details about the Pennsylvania fund appear in Appendix VI. A comparison of insurance rates in the Baltimore metropolitan area and the Philidelphia metropolitan area can be found in Appendix VII.

COLLATERAL SOURCES

Collateral source is a rule of evidence which prohibits introduction at a trial of any indication that a patient has been compensated or reimbursed for his injury from any source other than the defendant such as private health insurance or workmen's compensation. This area of tort reform tends to be very complex and volatile. A number of states have enacted legislation in an attempt to limit such duplication of payments. Elimination of this doctrine in Maryland would reduce liability costs.

CERTIFICATE OF MERIT

In 1978, California, enacted legislation to require medical malpractice complaints to be accompanied by a certificate from the plaintiff's attorney stating there is reasonable and meritorious cause for filing action as reviewed in consultation with a physician knowledgeable in the relevant issues. The Faculty prepared such legislation for introduction but declined to secure sponsorship for it because of other issues being pursued at the time. The committee agreed that this item may be of benefit.

COUNTERSUIT MODIFICATIONS

The present law provides that a defendant physician show particular and personal financial loss as a condition to countersuit. The committee believes that the physician's best interests are served by eliminating this condition as an impediment to countersuits.

CONCLUSIONS AND RECOMMENDATIONS

Health Claims Arbitration: This legislation has opened up the system for easy access by both attorneys and plaintiffs - one of the stated goals. But this has caused longer delays, allowed more cases to be filed and more awards made. Legal fees have increased. However, the HCA concept remains potentially attractive.

Recommendation: Support for the arbitration principle. However, the present Maryland system needs substantial revision to produce optimum results.

Expert Witness: This is a crucial issue in tort reform, especially with regard to definitions. Exploration of this area should be ongoing.

Recommendation: Support the need for more clearly delineating the expert witness in court proceedings.

Strongly support the principle of retrospective review of expert testimony presented in malpractice possibly by insurance carriers.

Cap on Awards: This idea remains attractive, especially if a cap could be placed on awards for pain and suffering. This represents the biggest potential savings for the public and for health care providers.

Recommendations: Support the principle of cap on awards.

Catastrophic Fund: With the present evidence on CAT fund performance it seems unlikely that such a fund will be workable or cost effective in Maryland. The concept of spreading the financial risk over a larger base of the population is reasonable and deserves exploration at the legislative level.

Recommendations: 1. Reject development of a CAT fund based on the Pennsylvania model. 2. Support the concept of risk spreading among a greater number of participants.

Collateral Sources: This area of tort reform is complex. The committee agrees it would represent a cost saving and would be supported by casualty insurers.

Recommendation: Support legislation eliminating the collateral source rule.

Certificate of Merit: This is an attractive, though not widely used idea. Draft legislation is already on file at the Faculty.

Recommendation: Support such legislation.

Countersuit Modification:

Recommendations: Support legislation eliminating special condition to countersuit.

MARYLAND GENERAL ASSEMBLY

A medical malpractice study committee has been established by the Legislative Policy Committee of the legislature. The committee will meet beginning in July, 1982. Committee members are:

SENATE	HOUSE
Harry McGuirk, Co-Chairman	Joseph Owens, Co-Chairman
Rosalie Abrams	Torrey Brown
Jerome Connell	Andrew Burns
Arthur Dorman	Joel Chasnoff
Louise Murphy	Ken Masters

There are to be no non-legislators appointed. The committee intends to hear testimony from all interested parties. Impetus for the re-creation of a committee of the legislature came from a number of different sources representing both plaintiffs and defendants.

Respectfully submitted,
Ad Hoc Committee on Tort Reform
Stanley Kirson, M.D., Chairman
Jose Martinez, M.D.
Donald H. Dembo, M.D.
Francisco Japzon, M.D.
Israel Weiner, M.D.
Neil Novin, M.D.
Gerald J. Carroll, M.D.
E. Kent Carney, M.D.
Gaylord L. Clark, M.D.
John King, Esq.
John Spinella

June 23, 1982

APPENDIX 1.

HEALTH CARE PROVIDERS - HCAO PARTICIPANTS
SPECIALTY COUNT

Allergy	4
Administration	6
Aerospace	0
Anesthesiology	42
Broncho-Esophagology	0
Cardiovascular Disease	36
Chiropractic	11
Dermatology	18
Diabetes	0
Dentist	314
Dental Public Health	0
Electroencephlograph	1
Emergency Medicine	21
Endocrinology	1
Endodontics	8
Ear, Nose, Throat, Echo	6
Fixed	1
Family Practice	85
Gastroenterology	22
General Practice	98
General Prev. Medicine	2
General Prev. Residency	0
Geriatrics	0
Hematology	5
Hynopsis	0
Infectious Disease	2
Immunology	0
Internal Medicine	160
Laryngology	0
Legal Medicine	1
L.P.N.	1
Maxillofacial	14
Neurology	15
Neoplastic Disease	0
Nephrology	7
Neurology, Child	0
Neuropathology	0
Nuclear Medicine	5
Nutrition	0
OB/GYN	141
Occupational Medicine	3
Oncology	7
Oral Pathology	3
Ophthalmology	44
Optometry	13
Orthodontics	29
Otology	0
Otorhinolaryngology	23
Pathology	29
Pathology, Clinical	0
Pathology, Forensic	0
Pediatrics	81
Osteopath	2
Pediatrics, Allergy	0
Pediatrics, Cardiology	0
Pedodontics	4
Periodontics	18
Pharmacology, Clinical	0
Podiatry	27
Prosthodontics	3
Psychiatry	51
Psychiatry, Child	0
Psychoanalysis	0
Psychosomatic Medicine	0
Public Health	10
Pulmonary Disease	12
Radiology	28
Radiology, Diagnostic	17
Radiology, Pediatric	0
Radiology, Therapeutic	0
Rehabilitation	24
R.N.	104
Rhoumatology	4
Rhinology	0
Surgery, Abdominal	1
Surgery, Cardiovascular	6
Surgery, Colon & Rectal	0
Surgery, General	128
Surgery, Hand	4
Surgery, Head & Neck	0
Surgery, Neurological	34
Surgery, Oral	32
Surgery, Orthopedic	101
Surgery, Pediatric	0
Surgery, Plastic	24
Surgery, Thoracic	17
Surgery, Traumatic	0
Surgery, Urological	43

APPENDIX I

COUNTY	HEALTH CARE PROVIDER	ATTORNEY	CONSUMER
ALLEGANY	34	4	14
ANNE ARUNDEL	108	74	217
BALTIMORE CITY	448	380	329
BALTIMORE COUNTY	351	157	530
CALVERT	9	3	7
CAROLINE	2	2	1
CARROLL	19	11	33
CECIL	11	4	2
CHARLES	9	6	8
DORCHESTER	9	2	5
FREDERICK	30	16	8
GARRETT	6	3	0
HARFORD	25	26	42
HOWARD	34	28	47
KENT	4	2	7
MONTGOMERY	389	288	142
PRINCE GEORGE	320	220	148
QUEEN ANNE	6	8	1
ST MARY'S	9	3	13
SOMERSET	3	0	3
TALBOT	26	7	13
WASHINGTON	34	14	10
WICOMICO	64	17	9
WORCESTER	4	3	1
	1,954	1,278	1,590

As of December 30, 1981

APPENDIX I.

HEALTH CLAIMS ARBITRATION OFFICE

CASE TOTALS

YEAR	NUMBER FILED	PANEL DETERMINATION	NON-PANEL DETERMINATION	TOTAL	CASES CLOSED IN EACH YEAR	CASES APPEALED
1977	2	2	0	2	0	2
1978	93	25	51	76	7	14
1979	269	68	132	200	41	24
1980	326	59	133	192	105	20
1981	428	19	78	97	273	4
*1982	186	0	5	5	146	0
	1,304	173	399	572	572	64

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*Through May 31, 1982
(In May: 40 cases filed, 35 closed)

APPENDIX II

HEALTH CLAIMS ARBITRATION IN OTHER STATES

Of the states (besides Maryland) using some form of arbitration or pre-trial screening, six replied to a query by the Faculty on the success of the program. The detailed breakdown of the responses is available from the Faculty office.

ARIZONA, enacted 1976

Form:	Pre-trial screening panel, decision admissible in court. Operated by the Superior Court of Arizona. The system is mandatory for claims over $50,000; the three panelists are a judge, health care provider and a lay person; hearings are informal and determine only a judgment for the plaintiff or defendant.
Results to date:	Volume of medical malpractice cases has declined; little impact on frequency or level or recovery by claimants; cases take longer to reach final disposition.
Major complaints and/or changes:	Administrative burden on court, scheduling and rescheduling of hearings a major problem, hearings have become protracted and conducted as minitrials. No anticipated remedies at this time.

DELAWARE, enacted 1976

Form:	Pre-trial screening panel, decision admissible in court. Operated by the Insurance Department of the State, the process is voluntary; Five panelists are attorney chairman, two health care providers and two lay persons. Hearings are informal and rule on standard of care and damages.
Results to date:	Panels working well and well accepted. 87 cases were received in period 1976-December 1981.
Major complaints and/or changes:	None identified by response from Department of Insurance.

INDIANA, enacted 1976

Form:	Pre-trial screening panel, decision admissible in court. Operated by the Insurance Department of the State, the process is mandatory; four panelists are attorney chairman, three health care providers. Chairman serves in advisory, non-voting capacity. Hearings are informal and determine liability only.
Results to date:	Panel hearings average 1-4 days, good acceptance by public and physicians, most finding for the defendant;
Major complaints and/or changes:	None identified by medical society or Department of Insurance.

NEW YORK, enacted 1974

Form:	Pre-trial screening panel, decision admissible in court when findings are unanimous. Operated by the Court, the process is mandatory. A judge is the chairman of three member panel including a health care provider and an attorney; hearings are informal and determine liability only.
Results to date:	None supplied.
Major complaints and/or changes:	None identified.

PENNSYLVANIA, enacted 1976

Form:	Pre-trial screening panel, decision admissible in court. Operated by a separate office of government, the once-mandatory system was overturned in 1980. Office now handles only those claims in which all parties agree to arbitration. The attorney is the chairman of a three member panel including a lay person and a health care provider. Hearings are formal and determine liability and damages.
Results to date:	Average length of hearing approximately 2 days. Data incomplete because of 1980 court decision. Panels well accepted by physicians, some attorneys; public largely unaware of system.
Major complaints and/or changes:	None identified.

RHODE ISLAND, enacted 1981

Effective May 18, 1981, Medical Liability Mediation Panels were abolished. Now, all actions for malpractice, breach of contract or negligence against health care providers are heard initially by a justice of the superior court. Following an evidentiary hearing, the justice must determine whether the evidence presented, if properly substantiated, would be sufficient to raise a legitimate question of liability appropriate for judicial inquiry or whether the plaintiff's case is merely an unfortunate medical result.

A breakdown of information on all other states using some form of pre-trial screening is contained in Medical Malpractice Pre-trial Screening Panels: A Review of the Evidence, published by the Intergovernmental Health Policy Project of George Washington University.

APPENDIX III

Attorneys who had handled cases for the Medical Mutual Liability Insurance Society were asked a series of questions regarding the working of the arbitration mechanism. 10 respondants replied to 19 questions about the system.

1. Do you believe the Health Claims Arbitration Law has resulted in an increase in case filings? 7 Yes 3 No

2. Do you believe that the HCAO is effectively performing its function of prompt disposition of cases? 2 Yes 8 No

3. Do you believe the Arbitration mechanism as it exists presently is providing justice:

   a. To the Plaintiff? 8 Yes 2 No

   b. To the Defendant? 5 Yes 4 No sometimes 1

4. Have you found the HCAO panel, not bound by the technical rules of evidence, to be: 1 beneficial 8 harmful

5. Do you believe that HCAO has resulted in awards that are:

   6 same as before 2 higher 1 lower

6. Have the changes enacted in the 1981 session of the legislature had any affect in making the Arbitration process more efficient, and the disposition of cases more prompt? Possibly 3 3 Yes 1 No

7. Does the special technical knowledge of a lawyer or physician panel member inhibit in any way the ability of the Panel to make fair and considered judgments in cases? If yes, please explain. 2 Yes 7 No

8. Of the cases handled before Health Claims Arbitration by your office, how many have been:

   a. Settled with a payment on behalf of the physician you represented 10

   b. Settled by a hospital or another Defendant not represented by you 16 # appealed 0

   c. Awards in favor of the Plaintiff 4 # appealed 4

   d. Non-meritorious cases (including those deposed of by summary judgment or dismissed) 3 Responded "many" 13 cases

9. How many cases have been settled on behalf of your physician Defendants in an amount of $100,000 or greater? 3

10. Do you believe that HCA has reduced the cost of litigation to:

    a. The Plaintiff 4 Yes 5 No

    b. The Defendant 4 Yes 5 No

11. How many cases have you handled which have resulted in a Defendant's verdict on behalf of your physician and which have subsequently been appealed by the Plaintiff? 13*

*Most had no stats on this.

12. Do you believe there should be a required filing fee similar to that required in court cases at the time the Plaintiff files his claim in Arbitration? 8 Yes 1 No

13. What specific legislative changes would you recommend be enacted if the HCA Act is not repealed?

There was a wide variety of answers and most attorneys zeroed in on two specific categories. The most popular suggestion was that the losing party should pay the cost. Four of the nine responding attorneys made this suggestion and one attorney also suggested that, in non-meritorious cases, the Plaintiff should have to pay the Defendants' attorneys' fees in addition to the cost of the proceeding.

The second most popular theme was the qualifications of the Panel Chairman. There seemed to be a general consensus that unqualified and prejudicial Panel Chairmen were being appointed on a consistent basis. Most attorneys who commented indicated that most of the Panel Chairmen appointed had a Plaintiff attorney background and little or no trial experience. The recommendations were as follows: (1) to upgrade the qualifications to become Panel Chairman; (2) appoint retired judges as Panel Chairman so that the Arbitration process could run more smoothly; (3) the Panel Chairman should have a minimum of trial experience either as an attorney or as a judge before being allowed to be the Panel Chairman; (4) appoint permanent chairman for a term of years, similar to judicial appointments. This way the cases could be assigned to a particular judge from the outset. The suggestion was made that the permanent Panel Chairman would be paid a reasonable salary for this service.

Several attorneys also indicated that they believed that the jury should not be advised of what the Arbitration Panel awarded, even though they would be advised as to who won in Arbitration.

Other suggestions include: (1) that the cost of Arbitration should be subsidized by the State in the same manner that the State subsidizes the cost of normal judicial proceedings; (2) that it should be mandatory that a physician participate as the provider member of the Panel and that he may not be allowed to step down at the 11th hour as has happened in many cases according to two of the responding attorneys; (3) Defendants should not be allowed to repeatedly change attorneys as a stalling tactic.

14. Do the physicians you have represented seem to prefer Arbitration to the judicial process? 7 Yes 2 No

15. In your experience, what is the average (approximate) length of time for the following:

a. Date you receive the case until Arbitration begins 16.3 Avg. (months)

b. Actual time of Arbitration proceeding 3.6 days Avg.

16. Do you believe the interests of your professional liability clients can best be served by the Arbitration mechanism?

4 Yes 5 No

17. Did you handle professional liability cases prior to the creation of the HCA law?

9 Yes 0 No

18. How many cases have you handled where there has been a Defendant's verdict and costs have been assesssd against the Defendant?

4 cases

2 responded they had many such cases

19. What change would you recommend be made in the Arbitration process with respect to procedure, discovery, rules of evidence, expert witnesses, etc.

In this category, there were only two responses. First, seven of the nine responding attorneys indicated that they believed that the rules of evidence should be more strictly adhered to. They believe that it can only help the Plaintiff to have hearsay testimony admitted on a regular basis. Second, was the suggestion that a uniform pre-trial procedure be adopted and that it be followed strictly in most cases.

APPENDIX IV

RESULTS OF SURVEY OF PHYSICIANS BY LEGISLATIVE COMMITTEE
ON
HEALTH CLAIMS ARBITRATION OFFICE

A questionnaire was sent to approximately 6,000
Faculty members.

A total of 553 responses was received in a survey of the effectiveness of the Health Claims Arbitration System of resolving Medical Malpractice cases.

Of the 553, 395 individual responses indicated they had no experience with the HCAO and they therefore, had no opinion with respect to its effectiveness or otherwise, although 390 indicated they approved of the system in principle.

Of the 158 persons who indicated they had some experience with the HCAO system, 152 said they approve of the system in principle, but six did not.

The experience of the 158 respondents were as follows:

a) 42 as defendant
b) 34 as witness
c) 87 as panel participant
Six persons served in more than one capacity.

Of the 158 respondents, 116 indicated they felt the process was fair; 20 felt it was unfair and 18 had no opinion.

Of the 158 respondents, 105 indicated their experiences were favorable, 33 unfavorable and 19 had no opinion.

Some Comments on the system:

1. Had been called to serve but had never been accepted. (most frequent complaint)

2. System was too slow and should be speeded up.

3. System was unfair, as panel chairman (the lawyer) swayed other members as to how to vote.

4. System was unfair, as it did not follow strict rules of court.

APPENDIX V

CATASTROPHIC FUNDS

A survey was conducted of states with CAT funds. The responses follow:

STATE	AMT & TYPE	MANDATORY INS. BY PHYSICIANS		FINANCING
		(YES)	(NO)	
Hawaii	Over $100,000 occurrence concept, actuarial basis		X	Md's purchase excess coverage from State based on % of basic coverage
Kansas	Over $100,000 claims made & occurrence concept, actuarial basis	X		Surcharge on basic insurance coverage
New Mexico	Over $100,000/ $500,000 occurrence concept, actuarial basis		X	33% of premium of $100,000/ $300,000 paid to CAT fund
Oregon	Program is inactive			
Pennsylvania	Over $100,000 claims made concept, no actuarial basis	X		Surcharge on basic coverage as determined by insurance commissioner
South Carolina	Over $100,000 occurrence concept, no actuarial basis		X	Quarterly payments to fund: 1st year 100% of basic coverage, 2nd-75%, 3rd-50%, 4th-25% any assessments set thereafter not to exceed 10% of basic coverage
Wisconsin	Over $200,000/ $600,000 occurrence concept, actuarial basis	X		Mandatory contribution based on fees set by Board of Directors of CAT Fund.

Most states surveyed felt the CAT fund had been helpful to physicians and most applied to all health care providers, not just physicians.

APPENDIX VI

PENNSYLVANIA CATASTROPHE LOSS FUND

STATISTICS:

Year	Payments from the Fund	Surcharges to health care providers
1976	0	10%
1977	$2,450,000	10%
1978	$2,250,000	0
1979	$7,750,000	0
1980	$8,850,000	10%
1981	$19,500,000	22%
1982	$27,000,000 PROJECTED	38%

At the present time, the fund has assets of $44,000,000 and earned interest of $7,800,000.

Payments from the fund do not include legal or administrative costs which are paid by the insurer. Pennsylvania has no statute of limitations. As of March, over 1,000 claims of over $100,000 in potential value were pending. If a claim is underreserved by the primary carrier and the award is over $100,000, the CAT fund will not pay.

COMPARISON OF PROFESSIONAL LIABILITY INSURANCE PREMIUMS PAID BY PHYSICIANS IN (a) PHILADELPHIA AREA OF PENNSYLVANIA AND (b) BALTIMORE AREA OF MARYLAND

	PENNSYLVANIA AREA (Philadelphia)			MARYLAND AREA (Baltimore)
YEAR	Category I (FP, IM, Psych) (no surgery) BASE PREMIUM ($100,000/300,000 Occurrence)	CAT FUND ASSESSMENT ($1 million/3 million) claims made basis	TOTAL	TOTAL ALL OCCURRENCE includes RSRF
1980	$1,704.00	10% - $170.40	$1,874.00	$1,592.00
1981	$1,704.00	22% - $375.00	$2,079.00	$2,152.00
1982	$1,883.00	38% - $715.54	$2,499.00	$2,647.00
	General Surgery			
1980	$10,428.00	10% - $1,042.80	$11,471.00	$9,109.00
1981	$10,428.00	22% - $2,294.00	$12,722.00	$12,288.00
1982	$11,523.00	38% - $4,279.00	$15,902.00	$13,742.00

NOTE: Pennsylvania CAT Fund is on a Claims made basis
Maryland is ALL occurrence

Insurance is mandated in Pennsylvania on all Health Care Providers

Observations on Medical Malpractice: Insights From An In-Depth Study of Medical Malpractice Case Files

By KENNETH S. ABRAHAM, Esq. and STANLEY M. KIRSON, MD

Mr. Abraham is an Associate Professor at the University of Maryland School of Law, while Dr. Kirson is Associate Clinical Professor of Surgery at the George Washington University Medical Center, Coordinator of the Surgical Residency Training Program at Silver Spring's Holy Cross Hospital and Chairman of the Montgomery County Medical Society's Malpractice Committee.

Introduction

We attempted to identify patterns of error and performance by members of the medical and legal professions by studying in-depth certain medical malpractice cases. Several dozen closed claims were carefully reviewed. Attention was focused on the conduct of the professionals involved, and the substance of both the medical and legal problems revealed in the files. The authors examined each file at length, reviewed their notes independently, and later summarized their opinions.

The common and recurring themes forming the central conclusions of the study are: 1) Despite protests to the contrary, some claims clearly have no merit and should not be filed; 2) Excessive faith by physicians in their own medical judgment is a definite contributor to malpractice; 3) The difficulty of accurate reconstruction of the medical events leading to the patient's complaint is a substantial obstacle to proper resolution of many cases.

Just as there is no single cause of the problems related to medical professional liability, there is no single solution. We decided to test some of the conventional thinking about causes and solutions by reviewing in detail a representative sample of medical malpractice cases. Our plan was to examine patterns of error and performance in our respective professions. We carefully examined defense files in several dozen closed malpractice cases in order to isolate problems which might be remedied without sacrifice of important values by patients, lawyers or physicians. Because our sample is small and because we were limited to defense files, our conclusions may inspire skepticism as well as interest. Nevertheless, interprofessional cooperation on this kind of project is so rare (we spent several hours studying and discussing each claim) and existing knowledge so anecdotal (our conclusions will not be surprising, but studies to support them hardly exist), that our insights are worth reporting.

Problems From a Medical Viewpoint

The medical issues revealed in the files involved misinformation or lack of information, problems of judgment and attentiveness, delay in therapy or diagnosis and improper or poor record-keeping. (The doctrine of informed consent is steadily becoming a more controversial problem. We encountered only one reference to this doctrine and breach of warranty was probably the real issue even there [plaintiff maintained that her physician assured her with 100% certainty of the freedom from pregnancy following tubal ligation]. Nevertheless, in view of many physicians' uncertainty about how much to tell a patient, and who in the courtroom setting will decide what constitutes informed consent, it seems appropriate to mention that further clarification by both courts and legislatures seems necessary.)

Misinformation

Certain deficiencies in care seemed related to the physician's lack of knowledge, or to misinformation. In a few cases, scientific data on the issue was so widely available that the physician's therapeutic or diagnostic choices were surprising. We particularly noted misuse of potentially toxic drugs for relatively minor ailments. In several cases we examined, use of these drugs (Chloromycetin, Neomycin) resulted in rather substantial disability. It is difficult to understand how physicians in these settings could have been unaware of the well-advertised and documented complications associated with these drugs. Because we could not interview these physicians directly, the question to some degree must go unanswered. In any event, it appears that even wider and more visible dissemination of information (in addition to the usual drug warnings) should be a continuing effort on the part of local, state and national medical groups. In some instances, even more specific or forceful guidelines than already exist may be required.

Judgment

Because patients and illnesses do not always fit into neat scientific compartments, physicians are often forced to make judgments that rely as much on educated impressions as on established fact. The necessity of such judgments has always been a self-evident truth to physicians, although it has been less well-understood by patients and (sometimes) the law; however, this should not excuse judgments that are arbitrary, hasty or ignore established facts. We observed a disturbing tendency in the cases we studied for physicians to rely exclusively on an initial impression or to be unwilling to follow an accepted but (to them) "mechanistic" approach to the management of a patient. In these instances, many acceptable modes of therapy to diagnosis were ignored, and consultations with associates were infrequent.

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Most examples of this "judgmental conceit" whichd-
we discovered involved delay or failure to obtain propt if
diagnostic studies where there existed compelling reable
sons to do so. These often involved possible digestions,
diseases, operative injury or vague systemic complai
In particular, laboratory or radiographic studiese them-
delayed or omitted, or were not critically or caing mal-
reviewed. In many cases, the physician noted ldependent
only his "judgment" concerning the patient's stility, then
explained the failure to follow standard procations.

One way to temper this ultra-subjectivitys to believe
for the physician to seek consultation with oted up against
non-conventional approach seems indicate opinions they
two obvious disadvantages to consultatio medical advice
possible fear on the part of some physiciaof frivolous suits

peers would view the physician proposing a consultaon as hesitant, evasive, uncertain or poorly-informed. Another is the extra cost and possibly uneven care that might result from frequent consultations.

There are dangers in prescribing this "cure," for the economic and medical costs of defensive medicine are already great. We define defensive medicine as the conducting of procedures or tests otherwise not advisable for the purpose of demonstrating in the event of a malpractice claim that comprehensive efforts were made by the physician on the patient's behalf. Physicians should not order such procedures, but neither should they refrain from conducting procedures or seeking consultations when possible medical benefits to the patient outweigh their economic cost and medical risk. Drawing the line between rejecting the unnecessary and protecting the patient is admittedly a difficult task. Placing undue faith in one's medical judgment in the face of an accepted or appropriate practice, however, ignores that tension: it constitutes "offensive" medicine and properly incurs liability for the injuries it causes.

Inattentiveness

In examining some files, we observed a lack of diligence on the part of certain physicians in follow-up care, authorizing premature discharge of the patient from the hospital, overlooked pertinent X-ray or laboratory findings and in continuation of potential troublesome medication. Although some of these deficiencies may be related to poor judgment, others, in fact, reflect a simple unwillingness to invest time and effort in thoroughly evaluating the patient.

Records

Medical malpractice claims often rely on office or hospital records for support. When the record is not thorough, the real condition of the patient is not apparent, even though care has been proper. Despite recent emphasis on written corroboration of the condition or management of a patient, our study demonstrated to us that the problem of inadequate or slipshod records has not been eliminated. Although it was an issue infrequently noted, the impact was substantial when it **did** occur, because inadequate records conveyed the impression that the physician either was not properly caring for the patient or was not very knowledgeable. On one occasion in particular, a dispute between the house officer and the attending physician over the presence or absence of a surgical injury to the ureter was recorded on a hospital chart. This was most damaging to the attending physician, **despite his apparently proper care.** We would emphasize, as others have, that clear and meticulous records, and appropriate comment upon the chart without personalizing or editorializing are most important. In particular, differences in viewpoint or treatment between house officers and attending physicians should be resolved before inappropriate and argumentative comments are entered on the chart.

Problems From a Legal Viewpoint—Frivolous Claims

Many physicians believed that a large percentage of medical malpractice claims are totally unwarranted, and many attorneys believe the opposite—that only a tiny percentage of all claims are frivolous. The answer probably lies somewhere in between these extremes. We do not know whether selfish financial concerns or the more admirable desire to assure justice was the factor motivating the attorneys' behavior in the frivolous claims we discovered; however, despite frequent protestations from attorneys that they turn away such cases, it is beyond dispute that sometimes they do not.

A minority, but more than a negligible portion of the claims we examined had **no** merit. None of these claims ever reached trial. Rather, each was abandoned by the plaintiff, sometimes on the court house steps, with no payment from the defendant or his insurance company, but this was not without cost: both parties and their attorneys had invested considerable time and anguish in these cases prior to their abandonment.

Another set of cases was "frivolous" in a different way. Although the claim that substandard care had been provided in these cases was plausible, it was clear that malpractice, if there was any, could not possibly have exacerbated the patient's disability. For instance, two claims involved fractures that went unrecognized for several days. But the patient suffered no harm at all from the delay in diagnosis, and therefore was not entitled to compensation.

Because medical malpractice cases are normally taken by plaintiff attorneys on a contingent fee basis, these cases were obviously bad business for the attorneys involved. They almost certainly received no payment for their time. These were usually not prominent members of the bar; they often had little or no experience in professional liability cases. The cases had apparently been filed without careful medical advice, perhaps in the hope (largely illusory in a case with **no** merit) of obtaining a favorable settlement.

We need inexpensive ways to show such attorneys that neither their clients' nor their own interests are served by initiating such suits. "Screening panel" review as mandated by legislation in over half the states will still require the investment of too much time and money on these frivolous claims.

Bar associations must emphasize even more strongly for their members the futility of filing claims before investigating them. Any formal or informal barriers that still restrict a patient's access to information about his treatment, or that in any way prevent an attorney from making a proper investigation prior to filing suit should be removed. Such restrictions encourage a "sue-first-and-ask-questions-later" attitude. Similarly, access to impartial medical opinions concerning potential claims should be facilitated. Most physicians are understandably reluctant to consult with plaintiffs' attorneys, but if it were easy for attorneys to obtain high quality, reliable medical opinions at the outset of their investigations, many potential claims might proceed no further.

We propose that groups of specialists make themselves available to attorneys contemplating filing malpractice claims. If these individuals provide independent and impartial medical evaluations without hostility, then attorneys may begin to rely on these evaluations.

The current climate encourages attorneys to believe that most of the medical profession is lined up against them, and to ignore any negative medical opinions they receive. Providing early and unbiased medical advice probably would discourage the filing of frivolous suits without imposing costly social and economic burdens on cases that do have merit.

Defining the Issue

We noticed a number of cases in which plaintiffs' attorneys ignored approaches that would have been much more productive than those chosen. For example, one case claimed surgical error when in fact the problem was probably related to preoperative medication. In another case, a dispute over proper treatment obscured what should have been the central issue: whether a delay in diagnosis caused the complications in question. Admittedly, these were cases of considerable complexity. Nevertheless, the attorneys' poor preparation and understanding of medical issues ill-served their clients under circumstances in which the defendant physician might well have been responsible for the patient's ailment.

The Reconstructability Problem

By far the majority of the cases we examined were impossible to evaluate with complete confidence because of what we shall term the "reconstructability" problem. In order to win a malpractice suit, a patient must prove two main points: first, that his physician committed malpractice—failed to conform to the standards of practice expected of those in his field, and, second, that this malpractice caused the injury of which the patient complains.

Proving malpractice is difficult enough. Proving causation, however, necessitates reconstructing the natural history of the patient's condition and then demonstrating how treatment affected it. Sometimes this is feasible; often it is extraordinarily difficult.

There are two main reasons for this difficulty. One is medical complexity. Where multiple procedures, therapies and complications have occurred, and especially where multiple organ systems are involved, accurate reconstruction of the causation sequence is often impossible. We encountered such problems as continuing hepatitis leading to a bleeding ulcer, and an aortic aneurysm complicated by gastric ulceration and thromboembolism following angiography. We doubt that anyone could have determined with confidence which was the "cause" of these complications: the medical treatment administered to the patient, or his underlying physical condition. A second difficulty is that in certain cases the "best" evidence is unpreservable.

On occasion, the quality of the physician's treatment depends on the acuity of his physical moves—for example, the esophagus is punctured during endoscopy—was the patient's tissue unusually friable, or did the physician err in the technique of his procedure? Such knowledge may or may not be availalbe. Some of it has been recorded, some is the product of the physician's senses at the time of treatment and cannot be completely preserved or precisely reconstructed. (The law has created a doctrine—res ipsa loquitur—to deal with the easiest of these occasions. When the injury in question does not ordinarily occur in the absence of malpractice, the jury may be allowed to consider the issue of liability. But often it is not possible to say whether such an injury to the patient, under the circumstances at the time, does or does not ordinarily occur in the absence of malpractice. In such cases the doctrine does not apply and reconstruction of the particular facts of the case at hand is a prerequisite to proper assessment of the merits of the case.) Though easily expressed, this incredibly complex reconstructability problem is at stake in many of the cases that are so casually dismissed by some observers as "obviously" unwarranted or "clearly" justifying liability.

We have no way of knowing whether attorneys and trial judges have been paying sufficient attention to the problems of reconstructing the causal sequence in medical malpractice cases. We suspect that some cases find their way to juries even when proof of the causal connection between the alleged malpractice and the patients' injuries is inadequate. Expert testimony on the causation question should be required unless the connection is a matter of common and easily understood laymen's knowledge. When this connection is vague, tenuous or uncertain, the law needs to accept what medicine has always known: that biological variation and the complexity of the human body will not always lend themselves to easy explanation.

Through the education they receive from their clients and expert consultants, physician's attorneys should be made even more aware than they are at present of the fraility and gaps in the state of medical knowledge. Sometimes even when the occurrence of malpractice has been proven, its causal relation to the patient's injury will be highly speculative. Under current law, there can be no liability under such circumstances. Trial judges must exercise their authority to keep cases from the jury when the requisite causal relationship has not been proved. To what extent this elusive issue now confounds decisions is uncertain. Members of both professions, but trial judges particularly, should be ready to uncover the hidden assumptions about causation underlying the claims they encounter.

Summary and Conclusions

A review of medical malpractice defense files revealed a number of phenomena which contribute to tensions in this area. From a medical point of view, we observed that such easily remedied errors as inattentiveness, misinformation and poor record keeping seem to contribute to malpractice claims. In addition, we noticed excessive reliance on personal judgment to the exclusion of other diagnostic means or consultation with associates. Despite its disadvantages, more frequent consultation may be advisable, especially where the physician recognizes that his choice of management is based on a highly individual judgment.

From the legal perspective, we noted the filing of frivolous claims, the failure of plaintiffs' attorneys to properly recognize important medical issues and the difficulty of accurately reconstructing the natural history of a patient's disability as a step in the logic of any claim. We propose that groups of specialists make themselves available to advise attorneys in advance of their filing suit. We also recommended increased recognition by attorneys and judges of the extraordinary complexity of biological functioning and of our relative ignorance about the "causes" of many disabilities. Many of the legal issues that depend on medical considerations simply cannot be resolved with any degree of certainty.

This study has revealed that at least some of the factors which have led to the current crisis are preventable and can be corrected within the professions themselves, but physicians, attorneys and judges must first come to recognize their own faults and agree to remedy them. They must act more responsibly and exert self-discipline to a greater degree than our observations suggest is already present. Trial judges must be willing to uncover agnostic assumptions regarding causation, and exercise their authority to control the course of a proceeding when it is proper to do so. Physicians will need to be candid, cooperative and forthright in assisting attorneys and the courts in pointing to medical error when it exists and they will need to be more precise and less independent in the day-to-day care of their patients.

Finally, attorneys will have to be more selective in their acceptance of cases, more thorough in investigating claims and more willing to acknowledge that sometimes, when medicine can provide no sure answers, the law will be unable to act. □

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JANUARY 15, 1986
STANLEY M. KIRSON, M.D.

PROFESSIONAL LIABILITY PROBLEM AND THE CONSUMER

Thank you for the interest in the liability problem which I believe effects all of you, not just in the health field. Most of you are involved in the business world and can understand the hard facts of numbers, and so let me give you some of them.

Approximately 15% of the 1984 health provider physicians services represented costs generated by the professional liability system. This was equivalent to approximately 11 Billion dollars nationally. Almost 3 Billion dollars of which was in doctor premiums alsone. 1.4 Billion in hospital premiums, 9 Million in office liability, 4 Million for non-physician personnel, 27 Million for hospital legal costs and a 15-30 Billion dollar cost for defensive medicine. The numbers are staggering and do not be fooled that these costs have not been passes along to you in you hospital bills and the increase in your hospital premiums for your coverage.

But also consider the practice of medicine. One of four obstricians in Florida have given up obstetrics and now there are several areas developing similar problems in the State of Maryland. Ten to fifteen obstetric/gynecology physicians have reduced or altered practice in some way throughout the nation. Approixımately one of four physicans report giving up risky procedures and in the Illinois poll, 28% of physicians polled stopped risky procedures and 42% stopped seeing certain patients with 18% claiming they felt a certain loss "nerve" in certain situations. If these are not frightening trends to you, they should be.

You should remember that this is not just for physicians. The property and casualty losses that are of a non-medical nature in1984 amounted to 21 Million dollars. All lines of general liability lost approximately 2.7 Billion excepting malpractice. Developing problems will be soon be availability rather than cost. Last year a dozen major companies dropped out of the market for architect insurance. Now there are only two or three left and the premiums are doubled. In New York, only one firm writes liability for accounts. Maximum limits have declined by 25% while premiums have increased 125%. Almost all insurance for midwives is gone, although an OB/GYN in Illinois may have an additional $6000. yearly to oversee his practice. Several operators of child facilities told congressional hearings they would be forced to close because of cancellation of insurance. It is almost impossible for contractors or engineers to find insurance regarding hazardous waste removal of clean-up. Municipal employees and in the product liability field have had their problems as well. The end result of this is the ultimate cost to you, the consumer, which is no services and no funds to be paid to you for damages. This has not quite made it appearance yet. The trend is clear. The final sacrafice, the final alternative will have to be a sharing of cost by limiting awards. Though this may seem unfair, it is going to be the only alternative unless the adminisrative and government restraint on state and federal levels can occur the sky rocketing insurance rates. It is no longer possible for the insurred to continue to pay high premiums and run a inordinate risks. It will be a difficult decision, the final decision is that of the consumer.

Thank you for your attention and if there are any questions, I will be happy to try and answer them.

PROFESSIONAL LIABILITY - A DIALOGUE: A CONSIDERATION OF MALPRACTICE MYTHS

STANLEY H. KIRSON, M.D. AND THE HONORABLE SENATOR SIDNEY KRAMER
HOLY CROSS HOSPITAL OF SILVER SPRING, MARYLAND
DECEMBER 17, 1985   GRAND ROUNDS

It is hardly a secret that the medical malpractice problem is our number one most notorious aggravation. The urgent need for significant legislative reform cannot be too strongly emphasized. Our discussion today will highlight only a few of the problem areas, with Senator Kramer providing his outline for the coming legislative session, and with time for audience questions.

No doubt that the malpractice controversy has polarized attitudes between lawyers and doctors.to the point that (SLIDE 1) physicians tend to respond rather antagonistically and unprofessionally, and (SLIDE 2) lawyers reply in kind with their opinion of medicine. Extreme opinion leads to extreme ideas which when repeatedly advertised assume unjustified believability and are called "FACTS." A careful examination, however, exposes them as myths.

The first of these is that there really is no crisis. One might argue this is truthful in the pure definition of the word "crisis", namely a decisive or turning point of great moment when danger or momentous outcome is decided. But considering the confusion of the last 5-7 years, certainly a "chronic crisis" exists when defensive medical costs are extimated*at 20-30 Billion and physicians premiums will move from 2.7 Billion 1984, to 3.6 Billion in 1986! The Rule of 20"s, as I have termed it, is illustrative.

Note that Nationally and in Maryland, only about 20% of cases are closed without payment - meaning, 80% for one reason or another, could not meet a test of substantial merit to warrant recovery. An 80% failure rate among any of us would I am certain, lead to quick termination of practice - and I would guess that this failure rate would hardly be acceptable in a legal practice either. What can you say about a system that is wrong 80% of the time but gives the recovering claimant only 20% of the total award? If this is not a crisis, it is certainly a great continuing disturbance. In any case, it is totally unacceptable.

(SLIDE 4) The next are part truths, and therefore part false. The law sees medical malpractice as the pristine pursuit of justice to redress damage to an unsuspecting patient by a bungling doctor. Medicine sees medical malpractice as a relentless attack upon reputation and earnings for unjustified cause by greedy attorneys and patients. His watchword is the second sentence. Medical malpractice may sometimes be both of these but more often it is neither. Understanding the real truth of this controversy hinges upon an analysis of the malpractice event itself, and exploring the behavior of MD's and lawyers within that event.

To try to define physician - lawyer weakness in the malpractice claim setting requires a systematic case by case review. Dr. Kenneth Abraham, Associate Pofessor of Law at Univeristy of Maryland and I attempted this in 1979 reviewing closed claim files in Baltimore, Maryland. The study took one year (SLIDE 5) and was published in the Maryland State Journay, November 1980. We reviewed the files searching for performance, weakness or deficiencies amoung the doctor - lawyer participants. Though our conclusions may not be surprising, a MD-lawyer collaborative effort of this type is rare enough to merit some attention.

(SLIDE 6) Physician deficiencies among these cases included examples of a lack of full information, especially about diagnostic studies and drugs, inatteniveness regarding patient care, unexplained delays in treatment or diangosis, and poor or inappropriate record keeping. We noted also a disturbing tendency among some physicians to ridigly formulate an opinion re-diagnosis or treatment and persist in relying upon judgment only, despite evidence to the contrary. This implied an exessive belief and dependence upon self, and in these cases alternative management was ignored, and consultations infrequent.

(SLIDE 7) Lawyer deficiencies included misidentifying the real issue within the claim, sometimes overlooking more likely malpractice issues, undoubtedly due to poor legal preparation. Frivolous and minimally meritorious claims were not frequent. Some were settled, others unceremoniously dropped at the courthouse steps, though not without emotional and economic sacrifice. Whether they were filed because of misinformation or in the illusory hope of some recovery was not clear. In any case, however, they were clearly unprofitable for plaintiff and counsel. The Reconstructability Issue was the most prevailing and perplexing problem. Reconstruction of events to show a line of responsibility from what the defendant did (or did not do) to the final injury was often inadequate. When multiple complex illnesses were present, exact causation was never clear. And when MD performance was examined, actual evidence for the misbehavior was unpreservable and not reproduceable for comparison (divided ureter, perforated esophagus) were the MD's moves rough, clumsy or faulty or were other impediments present that made injury inevitable? We could rarely andwer this question. The incredibly complex reconstructability problem is at stake in many cases that are casually assumed to be physician error and cause for liability. We concluded that this important issue was often mishandled by attorneys (perhaps by judges as well) and that cases without substantial proof of causation do find their way to the jury. The crucial message here is that physician - lawyer deficiencies are discoverable and correctable. Both professions need to exact greater care in their day to day practice, and they can if they desire seek out and correct these deficiencies. Attorneys must resist the temptation to equate injury to liability without solid investigation and must acknowledge limitations of the law when medical events are unclear.

In search for any answer at any price, many proposals to "correct" the malpractice problem have been advocated. Emotional and statistical defenses of these proposals abound. While proponents on both sides argue, the benchmark of successful reforms may be forgotten - namely, Does the reform decrease premiums and reduce the tendency toward defensive medical practice, and therfore costs? And does the reform correct the fundamental deficiencies in MD- lawyer performance?

(SLIDE 8) Altering legal ritual is not apt to be rewarding. Changes in Statutes of Limitations, counter suit modifications, certificates of meritorious claims, contingency fee modificatins have little chance of making a real impact (Rand Corp:Milman & Robertson).

Insurance Gimmeckry should be rejected as a solution. Claims Made Coverage, compensation funds, and Perfunctory Risk Management Programs are valueless.

Physician Negativism is certainly not an answer - avoiding risky practices, decreasing or moving practice, retiring or discountinuing insurance are all escape tactics only, not methods of confronting the problem.

WHAT WILL WORK?

A determined effort by leaders in medicine and law to correct deficiencies in both professions, even if methods may be punitive.

A substantial but reasonable awards limitation on both economic and nonecomomic recovery, retaining appeal procedures in selected cases.

(SLIDE 9) In this reference, such limitations continue to foster the idea of abridgment of constitutional rights, and certain equal protection rights of the 14th ammendment may be at risk when one population segment (the injured patient) is subject to a restriction not imposed upon any other segment. But consider this: An insurance system to cover malpractice awards cannot exist where obligations threaten to overcome collected funds. Such a system becomes unreliable and unsound. If because of this insurance were unavailable or so exhorbitant that only a select few could affort it, than health services are curtailed or disappear as providers move to limit their liability. The very purpose for which insurance funds were made available is now destroyed. Now a more important fundamental right of redress of greviences by compensation has been lost. A consumer must now make some compromise or remain uncompensated for damages. When affordability or risk threaten a service, risk spreading between consumer and provider becomes a means of preserving that service, and monetary risk sharing will then maintain goals of consumer and provider. The consumer here accepts a reduced award as the contribution toward risk sharing. This is fair as long as the award is substantial and reasonable. We have, then, a remodeling of one set of rights to avoid the more serious curtailment of rights of recovery at all if compensation or services were totally denied.

In conclusion, it is fair to say that the medical malpractice controversary has been the crusade of many and the failure of most. Genuine reform seems unlikely without 1) a sudden heightening of public awareness 2) Federal Government intervention or 3) professional leadership and a cooperative spirit to enfore standards of excellence among doctors and lawyers. Lacking these, we must turn to state legislatures to provide assistance and management. With that unpalatable thought I will reliquinsh the floor to Senator Kramer.

floor to Senator Kramer.

COMMENTS TO THE PROFFESIONAL LIBILITY AND COSTS LEGISLATIVE
SUBMOMMITTEE OF THE MARYLAND STATE LEGISLATURE
STANLEY M. FIRSON, M.D. SEPTEMBER 18, 1984

Ladies and Gentlemen of the subcommittee. I thank you for the opportunity to make some comments with respect of professional liability and the escalating costs which we have all recognized so well. I have divided my commentary into four catagories. The first of which concerns premium endemnity costs. Average physician pay-outs approximate 5-10% of physicians gross income. To most physicians, this is unacceptably high but prospects for a decrease are gloomy. Ample evidence exists for future escalations with awards and other insurance costs increasing as much as 100% in areas like New York and Florida. St. Paul and most other carriers predict an average 25-35% yearly premium increase. Claim rates to which premiums must be tied have increased from 3.3 per hundred physicians in 1978 to at lease 8 per hundred physicians presently over the country. The average claim nationally, where a hospital and a physician were involved, approximated $500,000. An average settlement in Florida was $198,000. In Maryland, an average award was $183,000. for OB-Gyn on the average, $79,000. in General Surgery, and $30,000. - $40,000. for Internist and General Practioneers, who did not practice surgery. An average award nationally in 1976 was $192,000., and in 1981 was $840,000., according to the Wall Street Journal of September 1983. The pattern of escalating costs seems very clear and quite dramatic. We naturally should ask ourselves if these trends are acceptable? Is there reasonable fairness to ask health care providers to idly accept dramatic and disabling financial increases as a cost of practicing medicine? The answer should be no. I do not believe that we have embraced the notion that because health care providers have substantial financial resources that they may be forever taped without restraint. Our health care system must be in great jeopardy if we do come to reach this conclusion. Our usual care system will certainly be under great strain as providers find that they cannot pass on even reasonable cost increases to patients and third party payors and that falling incomes cannot be justified in view of years of personal and economic sacrafice as well as intellectual preparation. And we also must ask whether or not the premiums we pay are justified. Health providers cannot be sure. We are at the mercies of the actuaries who plan 5-8 years in advance and project losses before they occur as methods of maintaining financial stability to their company. Doctors are more accustomed to dealing with real time current problems and dealing with health and disease as it exists now. Physicians still maintain substantial doubts that the premium rates are justified. However, we must acknowledge the grim statistics and awards and the meagre tort-reform efforts and we are forced to concead that despite our doubts, we need protection and have little choice. Your investigation of this matter would lie more with the insurance carriers remembering however, that there are two overwhelming difficulties.

First, that the language of the insurance business in almost unintelligable to the average individual.

Second, that when insurance carriers are not satisfied with their profit/loss ratios, they simply discontinue their liability business and move on leaving the consumer in this case, the health provider uninsured.

The issue of medical practice costs describes the indirect cost of health provider practice which has become re-orientated to accomodate the liability threat. It is a complex issue, not limited to doctors only and the exact cost is not easily defined. It is a unique and depressing form of economic behavior designed to support a defensive position for a prospective claim by managing the patient in ways that otherwise might be used. The term defensive medicine does not fully cover the scope of this issue. It is the sad end result on what has happened to the professionalism of providers when subjected to an abusive legal system. It may be divided conventiently into three groups.

1) Defensive Medical Practice where safe additional acceptable and protective practice occurs in an attempt to cover any and all posible alternatives. Examples would include the safe procedure such as additional laboratory work, x-rays or other consultations.

2) Offensive Medical Practice where the practices are performed to fully and complete substantiate a diagnosis but where those practices are somewhat more risky and harzadous then they are acceptable. They are done in defensive practice to cover all the options and possibilities less they be subject for a claim. The use of angiography and invasive techniques and endoscopy procedures are an example.

3) Non Medical Practice which is the entire and complete avoidance of certain practices and techniques because they are in fact too dangerous. The informed consent issue has become an example of both an offensive and defensive medicine. Here, a multitude of possible side effects and complications are revealed to the patient in an attempt to cover all bases. At the same time however, the revelation of some of the grim factors is extremely demoralizing to the patient themselves. Refusal of certain

services by providers have become other examples of both offensive and defensive medical practice. For instance, the AMA revealed that hospital facilities in Florida are progressively more reluctant to develop trauma centers. This is not only an attempt to protect the facility that avoids such a center but at the same time it diminishes the availability of such service to the patient at a time of urgent need. A successful suit in the State of Missouri was a good example, claiming that an emergency clinic failed to provide proper facilities and resulted in the death of a patient when the patient required hospital transfer.

The value and cost savings of the emergency clinics are well known but from now on in Missouri, the liability of such free standing clinics has certainly been highlighted and would be a chilling influence upon their popularity. In the obstetrical field a highly sensitive liability specialty, approximately 9% of physicians polled nationwide, have stopped performing deliveries. Twenty percent of those polled in Florida have stopped and 6% said that they restricted their surgical practice. They are instead, carrying out what we call non-medical practices or failing or refusing to provide certain services because of the liability threat. As part of the AMA survey nationwide, in response to the physicians opinions to professional liability risks, 40% of those polled claimed that they did in fact perform additional tests that might be considered defensive practice. Twenty-seven percent provided additional treatment procedures, 34% did not accept certain cases and 31% had increased their feas all as adverse consequences of the liability issue. Forty-four percent referred more cases to other doctors which might represent a possible positive outcome of the liability issue but certainly that also raises cost. Thirty-five percent said that they spent more time with patients. Fifty-six percent had more detailed records and 11% claimed to have hired more staff. These might be considered definitely beneficial.

On the horizon, more potential conflicts appear. Midwives for deliveries, the technology for life support, organ transplantation issues and reproductive genetic techniques. Where will the responsibility be when catastrophe with a newborn occurs with a non-physician delivery? Would any of you enjoy the thought of a murder charge placed before you because you acted in good conscience to discontinue life-support measures. Overatures have surfaced about "choices" in deciding which child will be a recipient of a liver or other organ transplant. You may be reassured that our legal detectives will find some way to make a case for the death of a patient denied an organ transplant. Legal issues have already surfaced regarding claims with reproductive surrogate parent situations.

Finally, there is the "hidden costs". This is the personal costs to the physician often unrecognized. It encompasses the personal physician stress of facing a possible suit for every action as part of his daily practice. Effective work and judgement can be altered. A dimension of loss of the patient and physician relationship must also be considered. These costs are seldom discussed and more difficult to define even in the professional cost of defensive medicine. To the degree that these factors adversely influence personal and professional treatment of patients, they are very significant. In the now famous Illinois Phychiatric Study 40% of physicians experienced some significant depression because of the constant litigation threat. Eight percent developed some specific physical illness and 33% polled sought early retirement because of the liability problem.

In summary, the Federal Government has clear designs in health costs regulation, some of which may be even beneficial and there has begun some intrusion related to compensation for identified occurances. The most critical point is the motivation for constructive reform and I emphasize constructive. The struggle to control the costs, and the conflict in the liability field cannot succeed unless lawmakers and to some extent the courts are convinced of the unacceptable and unworkable nature of the present system. I would urge you strongly to consider those matters related to costs which also integrate with true tort-reform. I would suggest to you that consideration of those issues which do not effectively and promptly lower costs will be a futile and time wasting exercise. Thank you for your interest and the priviledge of meeting with you here today.

MONTGOMERY COUNTY MEDICAL SOCIETY
15855 CRABBS BRANCH WAY • ROCKVILLE, MARYLAND 20855 • (301) 921-4300

MEMO

To: Jim Powell

From: Stanley Kirson, M.D.

Date: April 29, 1986

Re: Committee Hearings on S. 1804

I am enclosing a copy of an article I wrote which appeared in the Society's monthly magazine. I hope that this is useful to the Committee, as well as additional information being sent under separate cover.

Enclosures

The Health Claims Arbitration System

Stanley Kirson, M.D.*

Almost a decade has passed since medical malpractice suddenly became the most controversial and emotional topic in the health field in Maryland. Insurance carriers throughout the state, claiming that professional liability was too volatile and unpredictable, discontinued malpractice coverage, leaving physicians uninsured. Practice stoppages were threatened and health providers strongly pressed the state government under Marvin Mandel for a solution. It was agreed then, and even now, that the so-called crisis situation was artificially created by insurance carriers without cause and intended to increase premiums to cover other losses. The facts were simply that physicians no longer were insured and that without coverage, could not practice, thereby denying health service to the community.

From the turmoil of these days came two proposals: 1) the Medical Mutual Liability Insurance Company as the physicians' own company; and 2) the arbitration panel system and the Health Claims Arbitration Office. Both are still operative, though many questions of their effectiveness and benefits remain. The physician-owned Medical Mutual Liability Insurance Company has succeeded despite criticism of its conservatism and premium structure. As many companies throughout the country have since dissolved, the prudent philosophical approach by Med Mutual has seemed to have firmly established the company on sound reliable insurance grounds.

However, many sought more than just insurance coverage. Recognizing the dramatic changes in malpractice litigation, a plea was made for a real tort reform and the outcome was the Health Claims Arbitration Statute. This controversial act, even now, raises questions and debate as it did eight years ago.

What Is the Health Claims Arbitration Act?

This act was added to Maryland's Code under Courts and Judicial Proceedings which established the arbitration panel system and the Health Claims Arbitration Office (HCAO) as its administrative arm. It created an HCAO Director, defined the characters, duties and powers of the Director as well as selection and definition of panel members, outlined the procedures and defined the authority of claims and hearings, awards and appeals. It mandated that a three-person arbitration panel would, by law, be the first level of hearing of malpractice claims filed in Maryland in excess of $5,000.00. The panel would consist of an attorney chairman, a lay person and a health provider. The Maryland Rules of Procedure would govern and the verdict of the panel would include both liability and monetary awards. Appeals to both the panel as well as the court system were outlined. Any award, though applicable to the courts, was presumed correct and the party losing before the panel would have the burden of overcoming this presumption in court. Though not an actual part of the Act, additional legislation provided a change in the statute of limitations requirement, creating a five-year interval from the event or three years from discovery and providing the statute to toll from age 16 for minor children.

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*Dr. Kirson is a general surgeon practicing in Silver Spring and serves as Chairman for the Subcommittee on Tort Reform of the Med-Chi Legislative Committee.

HEALTH CLAIMS ARBITRATION (Continued)

What Was the Purpose of the Health Claims Arbitration Act?

The overriding concern of the unavailability of physicians' services spurred the formation of a legislative task force appointed by the governor. The arbitration panel was an answer to those critics claiming the need for real tort reform in addition to the creation of the Physicians' Insurance Company. The arbitration mechanism, though successful in some areas of dispute resolution, was relatively untested in the malpractice field. Supporters maintained that claims could be more quickly resolved, that ultimate fairness could be maintained and that an environment of informality would reduce the tensions of emotional and complex court disputes. The early California experience from the Ross-Loos Clinic (1935) and the cooperative Southern California Arbitration Project, which had begun in 1969, gave encouraging support to arbitration. Numerous courts have held that arbitration is not only acceptable but does not degrade common law. Many authorities, including the HEW Commission of 1971, have expressed optimism with arbitration mechanisms in the liability field. Presumably, the Maryland task force of 1975 was sensitive to all of these potentials of arbitration and looked upon it as a mechanism to begin real tort reform in Maryland.

What is it that the lawyers really oppose with respect to the HCAO?

At the beginning, attorneys argued that the HCAO system was unnecessary, that physicians were using their political strength to obtain reform, where it was not needed; insurance coverage was the only issue, they cried. When it became clear that the HCAO and panel system was to be law, the constitutional challenge became the new crusade. Now, the arbitration was unfair to plaintiffs, was costly, would result in a backlog of cases and denied trial by jury. Access to the court system and failure of due process were made part of the constitutional challenge. Court decisions in Maryland and the favorable experience of the HCAO, however, have reduced these complaints to historical interest only. No one seriously believes that parties are in any way denied justice with the arbitration mechanism. The arbitration experience, though hindered at first with threats of constitutional court challenge, as well as administrative uncertainty in the arbitration office, has been an outstandingly positive experience. The number of cases closed by all methods, including panel decisions, has increased steadily despite the increase in cases filed. In the last several years, approximately 100 cases more each year have been closed; of the 978 cases as of June 1984, 82% were only less than two years old. Data from the administrative office of the Circuit Court ending in FY 1984 reveals that a 19-month average is required to terminate tort cases other than malpractice ones. This is longer than the 16- to 17-month average which presently exists in arbitration. These figures become more impressive in support of arbitration, however, when the unavoidable early delays with the HCAO in its formative years and the greater complexity of malpractice cases are considered.

More recently, attorneys have fought the Health Claims Arbitration Office on the details of panel function. They assert that panel expertise is uneven among all members, that informality and lack of rules of evidence provide any and all testimony to reach the panel, and that the presumption of correction of the panel decision is an unfair burden and forces both sides to try their cases completely rather than maintain a more informal review-type of proceeding. There may be some merit to some of these complaints.

To this end, some of these problems have been addressed in Senate Bill 16, submitted this year to the General Assembly. This bill intends to establish some experience guidelines for lawyer chairmen, to raise the damage level for inclusion under the arbitration statute above the minimum of $5,000.00 and to allow rules of evidence to operate in panel deliberations as well as other modifications. The Medical and Chirurgical Faculty has supported these measures in the 1984 session and will hopefully support them again in 1985. It is safe to say, as is claimed and mentioned in the Management Analysis Study, that "when all litigants wish a speedy resolution of their case, they can generally be accommodated through the arbitration process."

Do You See Any Other Arbitration Problem Areas?

The informal environment of arbitration has been compromised and is a real disappointment of the system, though not mortal to the success of the process. This has occurred partially because of the burden borne by the loser before the panel which, in turn, demands no less than complete detailed preparation and trial by both parties. I don't believe this is the only reason for the lack of informality, however. Plaintiff and defense attorneys have been very vocal in their opposition to the arbitration process and have been unable to accept, willingly, the spirit of the arbitration method. Arbitration runs counter to their theory of practice and training. It remains an anathema to their way of existing with the legal process. It is a foreign concept; therefore, unacceptable; therefore, unworkable and to be resisted. The availability and competency of health-provider members and legal chairmen has been questioned also. Mandatory panel service should be allowed to satisfy jury duty (for all members), and fees for service should be increased to encourage participation. The health provider should represent, when possible, the specialty presented in the case at hand. Though this will require frequent use of specialists, the physicians can contribute to the effectiveness of the panel work if they respond to their professional duty by participating in a dedicated and positive manner. Careful selection of the legal panel chairman would provide the suitable, consistent authority needed in malpractice cases. Permanent chairmen corresponding to the eight Maryland Judicial Districts would be another option. In any case, panel chairmen need to be decisive in avoiding postponements and in moving the panel deliberations to a swift conclusion.

What Are Some of the Positive Features of a Panel System as it is Presently Operating?

Despite attorneys' protests that formality of the panel proceedings is lacking, most physicians questioned who have been defendants maintain a preference for the relative informality that is experienced in panel hearings. When compared to the courtroom setting, the arbitration system has been effective in disposing of cases and finding for the defendant in a substantial percent of the time; thereby, resolving the claim without recourse to the jury system and the courts. From 1977 to 1983, only 14% of cases filed were appealed and only a small number have been retried. Put another way, 86% of all filed cases are now being resolved through the arbitration mechanism, keeping the physician out of court. Clearly, duplication of trial is being avoided and a substantial diversion of these cases from the Circuit Court is maintained. And, as mentioned earlier, the time from filing to termination is shorter in arbitration than in the Circuit Court system.

HEALTH CLAIMS ARBITRATION (Continued)

What Is Your Answer to the Accusation that Some Physicians Are Opposed to the Panel System?

Some physicians are angered by the time required to serve on panel hearings and some feel that the compensation is too meager. Others are motivated by various political leanings and are sympathetic with legal and insurance groups eager to abolish the HCAO. There are some physicians, also, simply misguided, who believe that arbitration is somehow a disadvantage for the doctor or that it is too cumbersome, complicated and unnecessary. Thoughtful physicians, however, will recognize that the system works, can be made to work much better, and is capable of settling disputes outside the contention of the courtroom to the benefit of the physician. A statewide mail survey, conducted in 1981, revealed that, of 158 Med-Chi Faculty members who responded, as a panel witness, defendant or participant, 116 felt their experiences with the panel were favorable. The costs, delays and protracted hearings are a representation of a lack of cooperative effort and acceptance by all of the participants. The physician, at least, can do his part. He should remember: 1) 86% of the cases filed now do not reach court; and 2) without the arbitration mechanism, we go back to the more primitive days ten years ago with nothing more than our insurance company.

What Are the Prospects for the Health Claims Arbitration Office and the Arbitration System and, maybe, for Professional Liability Generally?

The undeniable facts are that cases of malpractice are among the most complex, that the economic impact is profound and that the emotional stress of all parties is great. For these reasons, efforts will continue to keep these cases from the usual court-jury system. To some degree, Maryland's arbitration experiment may point the way for other states by its success or failure. The potential for its success is very clearly evident, but all participants must support the process with a willingness to make the system work, and attorneys will be the greatest influence in this regard. If any panel system can gain reputation for fairness, speed and overall satisfaction of all parties, which hopefully we can do in Maryland, then that system will be quickly reproduced. Legal experts and the Federal Government have restated the need to avoid courts and juries and to improve the economics and fairness of present malpractice law. If states do not act, a Federal Statute certainly may be in the offing and previous efforts in the 95th and 96th Federal Congresses are noteworthy.

Regardless of the obstacles to no-fault doctrines (and there are many), this economic-legal-social experiment of holding all parties blameless but compensating the injured may need ultimately to be tried. A limitation upon awards is the most effective monetary correction that could be offered, but it is also shackled with controversy and a concern over constitutionality. It is unlikely, with these burdens, that it will become law in any form.

Though there might be some advantage to altering some of the concepts of the expert witness, this is probably a relatively minor contribution. After real tort reform by procedural change, as with panels or court substitutes, and economic change, such as award limitations, there is precious little else of real value that will influence our system. Changes in limitation statutes, collateral source rules, periodic payments, legal contingency fee regulation and certificates of merit would probably have little impact overall.

HEALTH CLAIMS ARBITRATION (Continued)

There is one certainty: the system can never return to the court-jury days. There are viable alternatives, and we will need to try them. Just as there are new methods and frontiers in medicine, there must also be new ways for the law to interrelate. Legal minds will need flexibility, creativity and tolerance to meet this challenge. Malpractice law, above all, seeks to discover if the doctor is responsible for injury to the patient. The physician must continue to act in a forebearing and cooperative manner during discovery and show, in a dignified, civil and affirmative way, that he is blameless of that responsibility. Lacking lawyer-doctor cooperation, we may expect the ever-continuing intrusion of state and federal governments into medical-legal affairs, a gloomy prospect, hopefully, unfulfilled.

For further information on this subject, the following documents are available by contacting Mr. Ed Shanbacker, Assistant Executive Director, at 921-4300.

The Med-Chi Tort Reform Ad Hoc Subcommittee Report

The Report of the Governor's Commission on Malpractice

Management Analysis Study of the Health Claims Arbitration Office

MEETING PRESENTATION
OCTOBER 8, 1985
TO
AMERICAN TRIAL LAWYERS OF WASHINGTON, D.C.

NATIONAL PASTIMES AND LOOPHOLES - A COMMENTARY ON MEDICAL MALPRACTICE

It should be said that our two professions are exhausting themselves in the malpractice conflict - time, money, self-respect, professionalism and public service are all becoming daily casualties of the battle. In the spirit of a middle ground, if there is such, let me share with you some observations after a decade of chasing the medical malpractice issue in Maryland.

To find order out of chaos is not easy, but we can direct our thinking somewhat by separating legal from economic issues without assigning preeminence to either. The legal themes interest me most and I emphasize them more theoretically than practically, apologizing in advance for my ignorance of the law. Permit me a few digressions along the way, and we may have time for some questions at the end.

Many fundamental differences between lawyers and doctors must be seen in the context of their training and practice. The medical malpractice issues have thrown our two professions together in a most dramatic way. The lawyer is trained to challenge vigorously positions of opposing parties, while simultaneously advancing the legitimacy of their own clients, guided and encircled with a structured, proscribed set of rules and laws. Many of his clients come voluntarily seeking redress. Your efforts in their behalf can be carefully prepared and orchestrated. It is often an unhurried event; time is your ally. The doctor, however, develops a diagnosis and embarks upon treatment not through debate but by an assessment of a mixture of dispassionate, natural, scientific events independently, without formal restraint except for those guidelines of acceptable patient management. Our patients seldom come willingly or fearlessly. Emergencies are common place and deliberation may not be possible. Biologic variations among patients are a constant challenge. Time becomes our enemy. Although these facts may seem self-evident, we seldom explore their deeper meanings which help explain our differences. No surprise a misunderstanding exists between our professions. A recognition and analysis of these factors will be necessary to rehabilitate congenial relations between us.

The present malpractice environment is clearly unworkable and unacceptable. A solution can be found only with doctor/lawyer collaboration unless the government intervenes or unless a rising tide of public consumer demand occurs. Given these assumptions, our two professions need much more intensive collective effort than we have evidenced up to this time. Compromise will require relinquishing traditional values and habits which have become the working fabric of our professional lives. This will be painful but necessary.

Understanding constant conflicts in medical malpractice is hinged upon an analysis of the malpractice event itself. For the physician, this is often seen as a relentless attack upon his reputation and earnings for unjustified cause provoked by greedy attorneys and patients. For the lawyer, it is seen as a pursuit of justice to redress damage to an unsuspecting client by a bungling, negligent doctor. It may be sometimes both of these, but more often it is neither. Then, what is the essence of the malpractice dispute? What about the behavior of the participants? What is dispensable and where are the errors? Dr. Kenneth Abraham, the University of Maryland Law School and I attempted to answer some of these questions by reviewing patterns of performance of physicians and lawyers as seen in closed defense files in Baltimore. We published our discoveries in November 1980 in the Maryland State Medical Journal. We collaborated by reviewing each case in depth independently and then discussing our findings together. We focused on the conduct and thinking of the participants and we tried to test some of the conventional thinking about causes and solutions to medical malpractice. We divided our findings into medical and legal categories. From the medical viewpoint, we were not surprised to find doctor failings, including misinformation or lack of information in certain areas, inattentiveness regarding general patient care, unexplained delay in treatment or diagnosis, and incomplete or inappropriate records. We also observed a disturbing tendency of doctors to form an initial impression about a patient's illness and doggedly adhere to it, unwilling to entertain other suggestions or avenues of management despite strong evidence to do so. The doctor seemingly based his opinion upon judgment and only reluctantly, if at all, changed courses. I term this mode of behavior "judgmental conceit" implying an excessive belief and dependence upon self. In these circumstances, acceptable alternative treatment was ignored and consultations infrequent, and the doctor himself noted earlier that only his own personal judgment and opinion was the sole defense for not following standard or successful care procedures. We noted that there are dangers in wholesale deemphasis of judgment in medical matters. Not only is it a valuable means of patient evaluation, but the substitution for it by expensive and hazardous consultations and testing is unwise. Physicians should not partake in this practice, but neither should they refrain from doing what is needed when benefits to patients outweight economic costs and risks. Placing undue faith in one's medical judgment counter to an accepted or appropriate practice ignores that dictum and constitutes offensive medicine and properly incurs liability for the injuries it causes. From the legal point of view, we considered the occurrence of frivolous claims, the problem of defining the real issue, and the problem of reconstructibility. A few cases were nonmeritorious, some unceremoniously dropped at the courthouse steps, but not without financial and emotional cost. In another way, some frivolous cases could not show that malpractice caused any injury. These were cases of minimal merit, whether they were filed because of misinformation or in the illusory hope of some recovery was not clear, but Bar associations should discourage these practices and try to work with doctors in removing barriers to full investigation of patients' records as well as securing impartial expert advice before filing. The reconstructibility or causation issue was by far the most prevailing legal problem. There were two considerations. First, the medical complexity where multiple factors are present; hepatitis, bleeding ulcer, aortic aneurysm, thromboembolism after angiography. Sorting out real causes becomes difficult. Secondly, in certain cases, the evidence for physician misbehavior is unpreservable (cut ureter or perforated esophagus). Were the doctor's moves rough or faulty or clumsy or were anatomical impediments so great that injury was inevitable? Though easily expressed, this incredibly complex reconstruction problem is at stake in many cases that are casually dismissed by plaintiff's counsel as obvious mistakes or clearly justifying liability. We have no way of knowing whether attorneys or judges were paying sufficient attention to these matters. We suspect and conclude from our review that cases without substantial proof of causation (or good supporting expert testimony to that issue) do find their way to the jury. When causal relationships are highly speculative, there should be no liability, but attorneys for both sides must be more aware of this issue. Trial judges must exercise their authority to keep cases from the jury when causality cannot be proven. To what extent this elusive issue now confounds decision making is uncertain, but attorneys and judges should be ready to uncover hidden assumptions about causation underlying the claims they encounter.

We finally concluded that judgmental error by doctors is a danger in incurring liability and that, from a legal perspective, the reconstructibility issue was equally significant. We felt that some of the factors we identified are preventable within the professions themselves, but that doctors, attorneys and judges must come to first recognize their own faults and agree to remedy them. Doctors need to be more candid, cooperative and forthright in assisting and uncovering the medical error when it exists, and they need to be more precise and less independent in their day-to-day care of patients. Attorneys need to be more selective in their cases, more thorough in investigating claims, and more willing to acknowledge the legal limitations when medical events are unclear.

There is another interrelated legal and economic issue that I would like to discuss or at least raise at this point. In the malpractice setting, it is fair to say that the real damage becomes the fact that everyone pays and no one wins and that personal freedoms are ultimately jeopardized on all sides. George Wilbur, columnist, said it well: "Our national pastime used to be baseball, but now it is constitutional rights." Americans seem to be addicted to reducing controversy into an argument over rights. Not that this is so bad, but we might ask for what rights are we considering. Certain it is that Fourteenth Amendment rights of equal protection may be at risk by a legislative restriction of one segment of the population while not affecting another. This particularly applies when we talk about award limitations for malpractice victims only. Defense of our fundamental and equal protection rights should always be vigorous, but there is another side here and, though defending award limitations in malpractice might be considered hazardous duty in this forum tonight, consider the following: An insurance system to cover malpractice awards cannot exist where obligations threaten to overcome the funds collected. Such a system becomes unreliable and unsound. If, because of this, insurance were unavailable or so exorbitant in cost that only a select few could afford it, then health services become restricted or disappear as providers move to reduce their liability. Then the consumer victim of malpractice has limited or no recovery. The very purpose for which insurance funds were made available is destroyed. In other words, where the maintenance of a public service depends upon the supplier of that service and where the affordability or risks of that service threaten its very existence, then risk spreading or sharing between consumer and provider offers an answer to preserving that service. Monetary risk sharing becomes a need to support the consumer and provider and the curtailment of awards in a way becomes the risk sharing contribution of the consumer. You may agree that this has a certain fairness, particularly if there remains a suitable limitation that will support the majority of claims with a fair, substantial and reasonable dollar amount. What we have is a remodeling of one set of constitutional rights to avoid a more serious curtailment of rights if compensation or services were totally denied.

My last comment concerns what has become a partial myth of the malpractice issue and this relates to the success of our panel system in the State of Maryland. It has been widely purported that this has been a failure and has been unpopular and has been difficult to maintain. As someone who was involved in the early origination of these panel systems, I would like to take issue with some of those thoughts. It certainly has been true that the panel system has been somewhat uneven in its function and there is legislation, to be hopefully passed in the 1986 Legislature, which may address some of these difficulties. However, as a general rule, the system has worked reasonably well with a substantial degree of fairness and the latest figures seem to support this. A review from the Johns Hopkins University has looked at the claim experience that has come up to 1982. Of 774 claims that were closed, 178 hearings were completed and 107 appealed. This appeal figure of over 50 percent gave the impression that there was broad dissatisfaction or unfairness with the system, but further figures carrying it beyond just the simple statement of the appeal rate indicated that 66 were filed in the circuit court and 28 came to circuit court trial, but at the end of the line only nine panel decisions were reversed. When one considers nine such reversals as opposed to the 178 hearings that were completed, we have a 5 percent reversal rate of all hearings, which represents a 95 percent confidence rate, or support rate if you will, in the original panel hearing so that we believe that cost and time have been preserved and that the ultimate goal has been maintained in that the original panel hearings have, to a high confidence level, been sustained.

I have some other things to discuss if time permits, but at this point it may be more appropriate to entertain questions from the floor, and I thank you for your time and attention.

STANLEY KIRSON, M.D.

SK:mdi:scc

ELEMENTS OF FINAL MEDICAL MALPRACTICE REFORM

* 1. Structured Verdicts: Verdicts over $250,000 structured; plaintiff receives a $250,000 lump sum up-front or up to 50% of future damages immediately for cause shown. Payment could continue after death of plaintiff, according to the actuarial projection of life.

2. Counterclaims: Abolition of requirement for showing special damages to countersue for malicious prosecution.

* 3. Pre-Trial Screening Panels: Three-member panel to screen medical malpractice cases for merit. Parties (whether plaintiff or defendant) proceeding against a unanimous decision of the panel and losing in court on the issue of negligence, pay other party's cost.

* 4. Contingent Fee Limitations: Sliding scale for contingency fees; 33 1/3% of the first $150,000; 25% of $150,000 to $1 million; 20% over $1 million. This applies to medical malpractice only.

* 5. Abolition of Punitive Damages: Punitive damages abolished for medical malpractice defendants, as well as for attorneys.

* 6. Collateral Source: Reduced 100%, but no more than 50% of judgment. Private and public disability income benefits and lost wages are exempt from the full offset; they are reduced by a factor of 50% as contained in current law.

7. Itemized Verdicts: Verdicts will be itemized.

8. Expert Witness: Expert licensed in same specialty as defendant. Court determines whether witness devotes an appropriate portion of time in practice, research or teaching of specialty.

9. Early Dismissal of Uninvolved Physicians: By filing an affidavit of non-involvement.

10. Untrue Allegations: Permits award of attorney's fees against plaintiffs for untrue allegations made without reasonable cause.

11. Meritorious Cause of Action: Affidavit of attorney indicating consultation with a physician who believes a meritorious case exists. At conclusion of case, permission for motion for attorney's fees against plaintiff, attorney or both, filed if untrue allegations were made. Such motion allows physician consultant to be examined in court.

12. Patient Records Release: Requires release of patient's records upon duly constituted request within 60 days. Current law requires release of patient records.

13. Insurance Reporting: Requires reporting by insurance companies of financial information. This information is already supplied to the Department of Insurance but will be submitted in more detailed form.

(more)

14. Medical Disciplinary Board Examinations: Allows the Board, during investigation of physician's competence and potential violation of the Medical Disciplinary Act, to compel any individual, licensed or certified, to practice, or who has applied for licensure or certification, to submit to a mental or physical examination or both. ISMS has previously indicated support for this concept.

15. Effective Date: The new law will take effect August 15, 1985.

16. Immunity: Protects from suit doctors and hospitals who revoke, suspend or otherwise limit medical staff privileges of impaired or incompetent physicians.

17. Cook County Court Calendar: Physicians and attorneys to press for creation of a special, segregated Cook County Court Calendar to hear medical malpractice lawsuits.

* OVERTURNED BY COOK COUNTY CIRCUIT COURT

Not Included:

1. Limitation on Non-Economic Damages: None.
2. Presumption of Wrongful Death: No change in current law.

Prepared by the Illinois State Medical Society - January, 1986.

NATIONAL
PERINATAL
ASSOCIATION

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TO: Senate Labor & Human Resources Committee

FROM: John V. Hartline, MD
President-Elect
National Perinatal Association

DATE: April 30, 1986

SUBJECT: Request to present oral testimony.
If impossible, please enter as written testimony.

As President-Elect of the National Perinatal Association, and as practicing physician, I have great concerns that the present effects of the liability crisis seriously threaten health care for pregnant women, their unborn babies and infants.

The National Perinatal Association is an organization of over 8000 individuals from all health care disciplines concerned with maternal and child health. Our membership includes obstetricians, pediatricians, neonatologists, perinatologists, nurses, nurse-midwives, social workers, dietitians, and hospital administrators, as well as, consumers. We believe in the multidisciplinary approach to promoting optimal perinatal health through education, research and supporting policies which improve maternal and child health.

Although I do not presume to have the answers to the many causes of the liability crisis, there is no doubt that the effect of the situation is to decrease the availibilty, accessibility, and potentially the quality of perinatal care. Physicians are rapidly leaving the practice of obstetrics. In some communities this has lead to no physician to provide prenatal care and patients having to travel considerable distance for delivery. Patients in the lower socio-economic brackets are disproportionately effected due to the higher risk of pregnancy, inadequate reimbursement, and fewer care givers practicing in the areas where they live.

Many advances in perinatal care have resulted from the application of multidisciplinary care. This care invloves certified nurse-midwives, nurse clinicians, social workers, nutritionists, and childbirth educators in programs of collaborative practice with physicians. These programs involve consultation, patient transfer when necessary for tertiary care, and active outreach educational and assessment programs. Resources to support these essential elements are diverted to liability costs in many areas.

Therefore many perinatal centers are unable to provide the full extent of those services. The system of regionalized perinatal care combined with the scientific advances of the past two or three decades provides the opportunity to reduce the mortality and morbidity associated with pregnancy to a minimum. Unfortunately, the present crisis has shifted the emphasis of doctors, certified nurse-midwives, nurses, related professionals and institutions to dealing with the liablity crisis.

The National Perinatal Association strongly supports the interest of Congress in the present liability crisis and offers to address the Labor and Human Resources Committee regarding the serious effects now being seen in these areas of concern to the National Perinatal Association.

Senator PELL. Then, in behalf of our chairman, who I know very much regrets not being here and would have liked to have been here and we will all have a chance to go over your testimony. I thank you for being with us, and the hearing is recessed until the call of the Chair.

[Whereupon, at 1:15 p.m., the committee was adjourned.]

FEDERAL INCENTIVES FOR STATE HEALTH CARE PROFESSIONAL LIABILITY REFORM ACT OF 1985

TUESDAY, JULY 22, 1986

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 2:20 p.m., in room SD-430, Dirksen Senate Office Building, Senator Orrin Hatch (chairman) presiding.

Present: Senators Hatch and Kennedy.

Also present: Senator Gore.

The CHAIRMAN. We are happy to welcome you all to our committee meeting this morning—or, this afternoon, I mean—I have been corrected by Senator Kennedy's staff, as usual, which is only right—I think to save time, we will put my 20-minute statement in the record, without objection.

[The Chairman's opening statement follows:]

OPENING STATEMENT OF SENATOR HATCH

Today we are convening a second day of hearings on the medical malpractice insurance crisis. I use that phrase guardedly because there is some debate as to whether there is a crisis at all. That's what we'll be debating with a distinguished panel of attorneys and insurance officials, and I hope they engage in a full airing of all issues involved.

But before we enter into that debate, I have to admit that I've been persuaded that such a crisis actually does exist. I believe our first day of hearings—which focused on the victims of the malpractice problem as will Mrs. McKnew today—pretty well settled that question. Let me run down for our panel today a brief summary of the testimony of the witnesses at that hearing.

A couple from Maine appeared holding their beautiful baby. The mother had worked with an obstetrician for eight years before achieving successful in vitro fertilization—only to find out that her doctor had ended his obstetric practice because of the unavailability of affordable malpractice insurance. As a result, throughout a high-risk pregnancy she had to endure extended high risk trips in the deadly Maine winter to see a new doctor.

An indigent patient without a regular doctor was turned away twice at emergency rooms—and had to deliver a beautiful baby in her car.

A clinic in nearby Prince George's County which serves 2,000 low income patients on a $100,000 annual budget because of the basically volunteer efforts of doctors—and had never been sued—lost its insurance. The carrier—appropriately named "Integrity Insurance"—later renewed the policy after a rash of news coverage. But there's still a good chance they will lose all their coverage next February—leaving those patients, including a young boy we met named John, without treatment for the psoriasis which covers his body from head to toe.

We heard from the only obstetrician available to serve low-income patients in a five-county area of West Virginia—who along with all of her fellow health care providers in the State was threatened with the imminent withdrawal of malpractice insurance policies. As it turned out, the insurance companies later relented—after the State legislature accepted their package tort reforms.

A top neurosurgeon from Florida—where 95 percent of the neurosurgeons have been sued—said that although he is compassionate, he no longer dares to lay a hand on the shoulder of a grieving parent to comfort them before an operation—lest he be misinterpreted as guaranteeing a successful result. The same neurosurgeon stated that certain malformations of the spinal cord should not be treated in this country with new, state of the art surgery because of the high risk of a lawsuit.

A brilliant black urologist from Chicago had risen from abject innercity poverty to the top of his field. He is the president of the Cook County Physicians Association—and used to be on committees dedicated to encouraging young people to emulate his example. But now because of the malpractice insurance crisis, he steers young people away from health careers—and encourages graduating medical students to avoid his specialty. "I am a product of the Equal Opportunity Dream," he said. "I overcame many obstacles . . . (but) this is one obstacle I may not be able to overcome."

Ladies and gentlemen, this troubles me greatly. I submit that this should not be happening in the greatest country in the world, with the greatest medical system in the world.

But it is happening—and it is affecting all of us consumers of health care. It is especially affecting patients who are faced with higher bills or greater inconvenience or lower quality of care, and those are the people I'm most concerned about. We will also be hearing from Louise McKnew, who represents the many patients who have suffered as a result of medical malpractice.

The real question is why this is happening. As I said, I would like a full airing of the issues today—but what I don't want is a lot of finger pointing. There is more than enough blame to go around.

What I do want to see is a willingness from all the parties represented here today to participate in a solution to this problem. I'd like to call on each and every one of you to get together with us and with each other and see if we can't find a way to end the human tragedy and waste of resources represented in the real-life examples I relayed to you.

Let us reason together—and let's find a way out of this crisis before the terrible costs to patients, doctors, lawyers, insurance companies, and society-at-large become too much for our health care system to bear. It may be a cliche by now—but I firmly believe that if you're not part of the solution, you're part of the problem.

I do want to say again how much I appreciate the willingness of our witnesses to appear today to pursue a possible resolution of this crisis, although I do regret that two of our invitees, high ranking executives of insurance companies, stated they were unable to attend today's hearing because of schedule conflicts.

The CHAIRMAN. Senator Gore, we will turn to you.

STATEMENT OF HON. ALBERT GORE, A U.S. SENATOR FROM THE STATE OF TENNESSEE

Senator GORE. Mr. Chairman, thank you. I will try to help you catch up on some time also by summarizing my statement.

I would like to begin by thanking you for the opportunity to be here, and I want to commend the committee for its valiant efforts to address the incredible problem of medical malpractice in this country.

Over in the Commerce Committee, we have been dealing with the same issue and different aspects of the same issue, and like you, we have found that medical malpractice poses an extremely serious threat to America's health care system.

The crisis has escalated because the average awards have reached $100,000 and sometimes exceed $1 million, and meanwhile, the skyrocketing price of malpractice insurance has led some doctors to quit the business and has made health care more expensive for everyone.

There is enough blame to go around, and we do not need to spend time here, sorting out all of the blame. The liability crisis is itself a kind of complex tort, with many people jointly and severally liable for the blame.

But under your leadership, Mr. Chairman, and with the able help of the ranking member, this committee is doing something about the problem, and I commend you for it.

You have introduced a bill that deals with a large part of the problem, seeking to bring liability costs under control. I share that goal, and I share the concern implicit in your efforts. I would like to outline another possible approach for the committee to consider here today.

I have introduced a bill today that does not deal with the entire problem; it does not solve the entire problem, but it does deal with one small piece of the problem, and I think it is an important step that will prove invaluable as we continue to tackle the tougher tort issues that remain.

This bill has been introduced over on the House side by Congressmen Wyden, Waxman, Madigan, and Tauke. It has been endorsed by numerous groups including the American Association of Retired Persons, the American College of Physicians, the American Hospital Association, the Washington Business Group on Health, and the inspector general of the Department of HHS.

It starts from the premise that in the long run, doctors themselves are in the best position to put an end to malpractice. As some of the most highly trained individuals in our society, physicians are ideally qualified to hold their profession to the highest standards. But they cannot police their own ranks effectively until Federal laws are changed to protect the peer review process.

Under current law, a doctor who testifies against a colleague can be sued for slander or restraint of trade. Physicians at a clinic in Oregon, for example, were ordered to pay $2 million in damages for revoking the privileges of a colleague that they had deemed incompetent. They had a professional peer review process, and they made a determination as to this physician's capabilities, and said no, this guy is incompetent, and revoked his privileges. Well, they were held liable for damages.

And very simply, what this bill does that I have introduced today is to give them some limited immunity from liability for responsible peer review which results in the removal of incompetent doctors that are judged incompetent by their peers in a process that meets certain standards of fairness and due process that are outlined in the bill.

The bill also provides for the sharing of information about incompetent doctors judged so by their peers, so that we can also address the problem of a doctor losing his license for malpractice in one area of the country and then skipping across the State line and setting up shop somewhere else. And as you know, that is all too common. And this bill would set up a databank that hospitals could use and that peer review groups could use.

So Mr. Chairman, I will not belabor it more than that. I will put the full prepared statement in the record. But I do very sincerely commend this bill to your attention. I feel that it will pass over on the House side this year. I want to emphasize that it is not a solution to the entire problem, but it is a doable piece of the solution for the entire problem. I hope that the committee will seriously consider it. I really do believe that, acting in conjunction with the House side, which expects to pass it, we could move at least on this part of the solution to the problem this year. And I look forward to working with you and other members of the committee in addressing other aspects of the problem as well.

I thank you for your time.

The **Chairman**. Well, thank you, Senator Gore. We appreciate your willingness to testify, and your leadership in this area. We are grateful that you came.

Senator **Gore**. Thank you, Mr. Chairman.

The **Chairman**. Our first panel will consist of: Myron Bromberg, Esq., of Porzio, Bromberg & Newman, of Morristown, NJ; David F. Shrager, Esq., of Shrager, McDaid & Loftus, in Philadelphia, PA; Stephen Belden, financial services officer of the Medical Services Division of St. Paul Fire & Marine Insurance Co., St. Paul, MN, who will be accompanied by Ms. Sally Narey Frans, who is senior government affairs manager; J. Robert Hunter, the president of National Insurance Consumer Organization in Alexandria, VA; Stewart W. Kemp, Esq., the director and chief counsel of the Massachusetts State Rating Bureau of the Massachusetts Division of Insurance, Boston, MA; and Ms. Louise McKnew, from Victims United, Bethesda, MD.

We are delighted to have you here today. As we did with Senator Gore, we will place all of your statements in the record as though fully delivered, and we are going to limit you to 5 minutes each so that the bulk of our time can be spent in discussion, and perhaps in debate among yourselves.

We do want to make a record on this, and we want to listen to you as much as we can today, but we are limited in time.

So we will begin with you, Mr. Bromberg, for your 5-minute statement.

STATEMENTS OF MYRON J. BROMBERG, ESQ., PORZIO, BROMBERG & NEWMAN, MORRISTOWN, NJ; DAVID F. SHRAGER, ESQ., SHRAGER, McDAID & LOFTUS, PHILADELPHIA, PA; STEPHEN BELDEN, FINANCIAL SERVICES OFFICER, MEDICAL SERVICES DIVISION, ST. PAUL FIRE & MARINE INSURANCE CO., ST. PAUL, MN, ACCOMPANIED BY SALLY NAREY FRANS, SENIOR GOVERNMENT AFFAIRS MANAGER; J. ROBERT HUNTER, PRESIDENT, NATIONAL INSURANCE CONSUMER ORGANIZATION, ALEXANDRIA, VA; STEWART W. KEMP, ESQ., DIRECTOR AND CHIEF COUNSEL, MASSACHUSETTS STATE INSURANCE RATING BUREAU, MASSACHUSETTS DIVISION OF INSURANCE, BOSTON, MA; AND LOUISE McKNEW, VICTIMS UNITED, BETHESDA, MD

Mr. **Bromberg**. Thank you, Mr. Chairman.

I would like to use the time allotted to me to direct myself to what I think are the distortions in the tort system, and particularly in the medical malpractice tort system, that have grown up not over hundreds of years, but rather over the last 5 to 15 years.

I say that because one of the objections that I sometimes hear to tort reform is that we should not tinker with a system that is several hundred years old. But the fact of the matter is that the distortions in the system have really crept in only over the last 10 to

15 years, and what we are talking about is getting this system back to where it was 15 or 20 years ago, so that it is operative and is not crippling in the many ways that it is today.

In medical malpractice, physicians face a series of twists in the tort law which have arisen over the past, roughly dozen years, that are placing them at a severe disadvantage and in a different position from other members of society in tort situations.

For instance, we have a number of States now that put a physician in the position of proving that he did not commit malpractice in certain situations, rather than the normal situation of having the plaintiff prove the defendant did something wrong.

We have cases where the physician is obliged to prove that he did not make a condition worse; for instance, where he fails to diagnose. It had been the notion, I suggest, for a long, long time that it was the obligation of the plaintiff to prove that had the diagnosis been made earlier, the condition would not have deteriorated. That law in my home State of New Jersey and a number of others has now changed; it is now the doctor's obligation to prove that if the diagnosis were made, it would not have made any difference.

We now have prejudgment interests in a number of States. That goes by a number of names, but what it means is that interest on a judgment starts to run not from the day that the jury comes back and the judgment is entered, but rather from the day the accident occurred, or the day that the suit was filed. And if the suit is around, as they frequently are in some States, for as long as 2, 4 years, even longer, and if interest is running at the vicinity of 8 percent, obviously, we can add to judgments as much as a third very rapidly. That did not exist 10, 15 years ago, and it is an enormous burden upon defendants that they did not face before.

Our damages law generally, not just in malpractice, but generally, has expanded tremendously in what has been thought to be progressive moves by the State courts. So that we now allow damages for a variety of forms of loss of services of a spouse, we allow damages for emotional shock or harm to another person. We allow punitive damages much more freely than ever before, and serious questions as to whether punitive damages belong in the law of medical malpractice at all.

We allow people to collect damages when in fact they have never sustained them. We have a system of citation called the collateral source rule which the present bill attacks, by which a person is actually paid, receives payment from Blue Cross/Blue Shield or whatever and then sues again, and one is not allowed to tell the jury in defense that this person has already been paid. So the person collects once from their own insurance company and then sues again for it in the suit. That is only one example of the collateral source rule. It extends to things such as income tax. If a person loses wages, they sue for their lost wages, and the jury is not told in many States that there is no income tax on recoveries in tort actions, personal injury tort actions.

There are recoveries now for increased future risk. I was taught sometime ago back in law school that you recovered only if it was probable that something was going to happen to you in the future. That is not the law anymore in a great number of States, and in malpractice actions as well as others, one can recover for the fact that one has a greater risk of having damage happen to them in the future.

The statute of limitations in malpractice has really become a mockery over the last 15 years. We have developed what is called the discovery rule, and the discovery rule says that you do not even start to have the statute of limitations run against you if you are a claimant until you discover that malpractice has been committed. Well, that is subject to all sorts of testimony, and in effect the exception has swallowed the rule.

The CHAIRMAN. Well, in effect, it just allows the suit to be brought any time a doctor says there is malpractice.

Mr. BROMBERG. Yes, and any time that a plaintiff says, "Well, I did not know there was malpractice. I did not know that it would cause the injury."

The CHAIRMAN. Sure.

Mr. BROMBERG. And so a doctor may face a suit 30, 40 years, actually, after the malpractice was committed. And we have got to remember what inflation has done to insurance. I told people back in 1960, thinking I was giving them good advice, "You get $100,000 of coverage, doctor, and you are well-covered." Well, if that doctor is sued now, 25 years later, for something he did 25 years ago, he is sitting with $100,000 in coverage, and a suit that was a $100,000 suit then is $1 million or more than that now.

The problem of joint and several liability has become a severe difficulty. Many States now have comparative negligence. If you are found 1 percent at fault, and the other people in the suit are 99 percent at fault—let us say the other defendants are 99 percent at fault—you are 1 percent at fault under the law of almost every State, and the other defendants cannot pay—either they do not have insurance, they do not have funds, whatever, but they cannot pay—you are obliged for your 1 percent to pay the whole kit-and-caboodle. And that, I submit to you, just does not make a lot of sense. But that is the law, and that is joint and several liability.

The CHAIRMAN. Your time is up, Mr. Bromberg. But let me just say that you have raised come very important points that we need to address.

[The prepared statement of Mr. Bromberg follows:]

STATEMENT OF MYRON J. BROMBERG
BEFORE THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
ON THE
MEDICAL MALPRACTICE INSURANCE CRISIS

Myron J. Bromberg
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When I first defended physicians in medical malpractice actions twenty-five years ago, very few cases were lost by physicians. The necessity of expert testimony on behalf of the plaintiff indicating a deviation from accepted standards of medical practice created a frequently insurmountable barrier for the plaintiff. The "conspiracy of silence" among physicians made it extremely difficult for plaintiffs to obtain credible expert witnesses. Although the word "conspiracy" was probably inaccurate, there was in fact a strong reluctance on the part of physicians to testify against others in their guild. Such conduct was considered a display of bad manners, if not downright traiterous.

The frustration of plaintiffs with valid claims and the injustices which resulted caused a swing of the pendulum as to expert testimony impelled by both court decisions and changes in the attitude of medical professionals. Starting about fifteen years ago, the courts became increasingly liberal in permitting "experts" to be qualified to testify even when they practiced in fields of medicine other than the field of the physician-defendant, and where their qualifications were so thin that they might have been rejected as experts in other types of litigation. This change in attitude by the courts resulted in more cases reaching a jury rather than being thrown out, but it continued to produce a rather poor quality of expert witness for the plaintiff.

I can well remember my own delight at the ease of constructing a cross-examination of physicians who really did not practice medicine, but rather spent their time writing tracts which bordered on the irrational on both medical and non-medical subjects, and who were easily exposed as bogus.

That situation no longer exists. The medical profession itself responded to a growing public disaffection resulting from a perception that doctors could stand above the law by the simple device of refusing to testify against each other. Today, it is common for a lawyer defending physicians to have to face plaintiffs' experts with superb medical qualifications and training., The medical schools have provided a rich source of well qualified experts. In addition, many of today's leading practitioners are perfectly willing to testify for a plaintiff in a case where they see a deviation from accepted standards. This change in the availability of qualified experts has been a principal factor in increasing both the number of medical malpractice actions brought as well as their successes.

At the same time, the courts were reacting to the "conspiracy of silence" by greatly liberalizing the legal rules applicable to medical malpractice actions. This liberalization has created some tort rules that apply to physicians without applying to the rest of society. These are rules which, in my view, are demoralizing for the medical profession. They are rules that physicians find injust and, I suggest, are in fact injust.

Let me offer two examples, drawing upon the law of my primary state of practice, New Jersey. Within the last few years we have developed certain rules which shift to a defendant-physician the burden of proving freedom from negligence. At almost all other points in the law of negligence, it is the burden of the plaintiff to prove that damages are the result of the defendant's actions. In the case in which the rule was changed as to surgeons the patient underwent a back operation at a New Jersey hospital. During the course of the surgery, a medical instrument known as a rongeur snapped, causing nerve damage. The jury was unable to determine whether the accident was caused by some defect in the manufacture of the surgical instrument, by the hospital's improper maintenance of the instrument, or by something the physician did in using the instrument. The plaintiff having failed to carry his burden of proof, the jury dismissed the case as to all defendants. The Supreme Court of New Jersey held that this result was unacceptable and the jury would have to assume that each of the defendants was at fault, unless the defendant could prove otherwise. Anderson v. Somberg, 61 N.J. 291, 338 A. 2d 35 (1975). The case obviously has application beyond its own facts. New Jersey physicians, therefore, became a singular class responsible for proving they did not commit a wrong. Although the case is civil rather than criminal, it has an obvious parallel to a criminal case in which a defendant would have to prove that he was not guilty of a crime. That is precisely how physicians view the law.

In another case, in which a physician missed a diagnosis of a disease, the plaintiff failed to prove that if the diagnosis had been made, a cure would probably have been effected or, at least, the disease would have been less serious. Fosgate v. Corona, 66 N.J. 268, 330 A. 2d. 335 (1974). Here, the New Jersey courts determined that the burden was not upon the plaintiff to prove a cure would have resulted, but rather upon the defendant-physician to prove that an earlier diagnosis would not have resulted in a cure. To those accumstomed to dealing with rules of causation and damages in tort law, this is a bizarre result. Again, it is a special rule constructed for physicians which puts them at a further disadvantage in malpractice litigation.

At the same time, a great number of states have adopted the so-called "discovery rule" in regard to the statute of limitations. This means that the statute of limitations does not begin to run in favor of a physician if the plaintiff can show that he was not obliged to "discover" that his injury was caused by the phsycian's malpractice. To those of us attempting to defend physicians, this exception seems to have swallowed the rule. It is a rare occasion when a medical malpractice claim can be barred by the statute of limitations, so long as the plaintiff today alleges that either he did not know of the injury or that he did not know that what the physician did represented a deviation from accepted standards of medical malpractice. Bear in mind that physicians have always had to face greatly extended statutes of limitations when treating children (as to whom the statute of limitations normally does not begin to run until they are adults under the law). This matter of the statute of limitations extension can be economically disastrous for a physician. I remember well advising physicians in the early 1960s that $100,000 of liability insurance was adequate coverage for them. No one in those days could foresee that the day of multi-million dollar verdicts lay ahead. We now defend physicians for treatment they rendered twenty and thirty years ago, and the verdicts against them will be measured in the minidollar of the 1980s, although their insurance coverage is fixed as set in the 1960s.

Of course, insurers likewise are obliged to pay judgments or make settlements that reflect the enormous costs of inflation, which in the main was unanticipated.

In my practice, I see not only the financial but the psychological effects of our greatly liberalized malpractice rules. I can assure you that for many physicians, malpractice cases are not merely an annoyance, they are professionally disabling. I have defended surgeons who were so distracted and crushed by the weight of a pending malpractice case that they were unable to perform surgery. The pendency of the case and the potential for financial disaster have so shaken their confidence and composure as to prohibit them from functioning in their professions. I have seen physicians whose attitude towards their patients become so jaundiced as a result of malpractice actions that they treated patients as adversaries to the mutual disadvantage of physician and patient. I have seen good physicians leave New Jersey when they felt that the malpractice climate there was intolerable. I have seen physicians leave private practice to seek the shield of hospital or HMO practice when, in fact, they were clearly more effective practitioners in their own private practices. I have seen good physicians retire prematurely because, in their words, "all of the pleasure has been taken out of the practice of medicine".

As a lawyer, I have been trained to maintain great respect for our institutions. Lawyers are not often zealous advocates of radical changes in the law. However, while I counsel strongly against throwing out the baby with the bath water, I nonetheless recognize that it is poor hygiene to continue bathing the baby in dirty water. The bath needs an infusion of fresh, clean water.

I suggest to you that a "cap" on damages may indeed come very close to including the baby in the effluent. However, I cannot understand arguments that oppose periodic payments of damages or the elimination of the collateral source rule. These are changes in the law which can only be salutary.

The CHAIRMAN. I have an executive officer here, and I need to talk with him. So I am going to recess for just 3 minutes, and then we will come right back to you, Mr. Shrager, if we can.

[Short recess.]

The CHAIRMAN. Mr. Shrager, sorry for the delay.

Mr. SHRAGER. Thank you, Mr. Chairman.

My name is David Shrager. I am an attorney who has been in practice for about 25 years in Philadelphia. I have represented physicians, but very largely, I have had the privilege of representing health care consumers, and I have served in the past as president of the Association of Trial Lawyers of America.

I am going to try to make this brief and, with the chairman's permission, introduce the long form of the statement into the record.

The CHAIRMAN. Without objection, we will put it in, Mr. Shrager.

Mr. SHRAGER. Thank you, sir.

The CHAIRMAN. We are well familiar with you, too, and I have lots of sympathy for your side as well. It is a tough position to be in.

Mr. SHRAGER. Well, you can test your former position on the basis of the answers to certain questions, the factual predicate for which I hope you will be able to develop and go wherever the facts take you, sir.

The CHAIRMAN. OK.

Mr. SHRAGER. This debate, as you well know, has been characterized by many horror stories told by insurance company executives and physicians and even trial lawyers, all characterized by their well-known biases and hyperbole. I think the best I could do in terms of sharing something useful with the committee is to suggest certain questions that you might wish to ask and certain facts that you might want to develop and where those facts could be accessed.

I proceed, sir, on the following premises. First of all, the overriding public policy benchmark for decisionmaking in the medical malpractice field should be the interest of and the impact upon the actual victims and the potential victims, the potential victims being the almost 100 percent of our citizens who are health care consumers.

Second, I have always supposed that those who wish to have legislation enacted at the Federal level, especially, should bear the burden of proof based on facts, not anecdotes and legend, that there is a clear and compelling need for action at the U.S. Congress level.

Third, that wise decisionmaking in legislation is always at risk when it proceeds on the basis of editorials, public relations campaigns and scare stories. The Republic seems to have survived rather well, despite the assertion of crises periodically announced by powerful private sector interests.

Fourth, we think that regard for our Federal structure should always challenge the Congress to the threshold inquiry of whether it is right and proper to assume that there is a greater repository of wisdom in Washington, DC. than in the legislatures of the several States when it comes to striking a proper balance between the rights and responsibilities of health care providers and health care consumers.

I would say, Mr. Chairman, this is especially true when the momentum for national legislation comes from private sector groups who have traditionally abhorred Federal action in every, single field, and with respect to every subject matter, except when, as in the present example, there is an effort to limit legal responsibility. I would point out that the very groups involved here, the professional and business groups, are groups that have traditionally been the subject matter of regulation at the State level.

And the final premise, sir, is that professionals, including physicians and attorneys, should be held to the highest standard of conduct and responsibility toward their patients and clients. I have always supposed that proposals which limit such responsibility should be treated as suspect, especially when they tamper with institutions and principles long thought to be fundamental to our justice delivery system.

The several areas, just to mention them and then conclude, sir, that you might want to inquire into these hearings would be first, the existence of the relatively few physicians who generate a disproportionate amount of insurance payments. There is an enormous body of data available from the insurance carriers, commercial and noncommercial carriers, which indicate that approximately 1 percent—it varies from State to State—of physicians seem to generate losses that are in the range, depending again on the State, anywhere from 25 percent to, in the case of Florida some have urged as much as 50 percent.

Surely, peer review, better licensure requirements, getting the medical review boards out of the mainstream bureaucracy in the States, could without taking a single penny out of the pockets of innocent victims of malpractice do very much. The same could be said about risk management techniques.

Second, sir, an area of very important inquiry would be for this committee to seize the occasion to inquire into the operations of the insurance industry and to really determine in plain English fashion what the financial facts of life are and how physicians are classified for premium purposes.

The questions we raise are why is there such a wide disparity in the premium amounts paid by certain physicians and whether these disparities are fair; how much in premium dollars is being taken in, and how much paid out; whether, as trial lawyers keep claiming, overall the amount of investment income very largely approaches, if not exceeds, the amount that is being paid out. This data is all available readily from the industry.

This committee could also add enormously to public understanding of the issue if we could learn why it is that general practitioners, for example, pay perhaps an average of $1,500 in many States, and yet, certain high-risk specialists, neurosurgeons, anesthesiologists and others well outside the increased economic return that they get are paying 10, 20, or 30 times the amount.

I can illustrate it very quickly here in the District, where the medical directory will indicate there are about 30 neurosurgeons. Under any kind of reform, if the tort system were essentially abolished almost, if those 30 neurosurgeons were charged $100,000 apiece, a single verdict, without reference to general damages, for economic loss of a catastrophically injured youngster could wipe out the premiums—one case in one year.

Many observers of the insurance system feel it is wrong and even bizarre that the men and women of the profession who are in the high-risk specialties, who have removed the risk from the shoulders of their many larger, at less risk colleagues, are paying a disproportionate amount, that the risk classification should collapse.

Two quick points, and let me conclude, sir. I would ask you to consider, sir, whether you would want to take inventory of what the experience has been in the States. The States have acted, rightly or wrongly. Many States have acted. There are more than 10 States that have in place substantive changes in tort law as it impacts on the malpractice.

The CHAIRMAN. Please make your last point, Mr. Shrager, because your time is up.

Mr. SHRAGER. OK. I will be happy to, sir.

I have not in my statement addressed myself to specific changes in the tort law. And the reason I have not done so is that I personally, sir, would not support a single compromise of a single health care consumer's right, not because I think there is any life tenure to certain rights that we have as citizens, but because I have not yet seen—and I would invite the committee to test—whether there is a factual predicate in place to show such an overwhelming public need to take away the rights of any injured health care consumer in this country.

Thank you, sir.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Shrager follows:]

STATEMENT OF DAVID S. SHRAGER
TO THE UNITED STATES SENATE
COMMITTEE ON LABOR AND HUMAN RESOURCES
Tuesday, July 22, 1986

My name is David S. Shrager. I have been a practicing attorney for more than 25 years, with offices in Philadelphia, Pennsylvania. Much of my professional practice involves negligence claims on behalf of health care consumers. I have had the privilege in the past to serve as President of the Association of Trial Lawyers of America (ATLA).

The subjects of medical malpractice, medical malpractice insurance and so-called tort reform have received considerable partisan attention and rhetoric but, unfortunately, little thoughtful analysis from critics in the private and public sectors. The debate has been characterized by horror stories told by insurance company executives, health care providers and attorneys - all proceeding with well known biases and hyperbole. If this subject matter is to be intelligently understood, it would be well for these contesting groups to lower their voices, agree on what we know or more importantly what we don't know, share with this committee those questions which it might wish to have answered in order to establish a proper factual predicate for its further deliberations, and describe where and how it can access the facts. We proceed on the following premises:

1. The rights of our citizens to fair compensation for negligently inflicted injury are fundemental and will not be lightly abridged or compromised.

2. The overriding public policy benchmark for decision making in the medical malpractice field must always be the interests of, and impact upon, the actual victims of malpractice and the potential victims - the almost one hundred percent of our citizens who are health care consumers.

3. Those who wish to intrude upon the busy agenda of the United States Senate bear the burden of proof of demonstrating that on the basis of the facts - not anecdotes and legend - there is a clear and compelling need for action by the United States Congress.

4. Wise legislative policymaking is always at risk when it proceeds on the basis of editorials, public relations campaigns and scare stories. The Republic seems to have survived rather well despite the assertion of "crises" periodically announced by powerful, private sector interests.

5. The United States Senate, thought to be the nation's most deliberative body, should proceed to decision making with all of the facts it reasonably can access, in a thoughtful and

thorough manner, without engaging in a rush to judgment based on premises frequently articulated but never factually proved.

6. Due regard for our magnificent federal structure should always challenge the Congress to the threshold inquiry of whether it is right, proper and wise to presume that there is a greater repository of wisdom in Washington, D.C. than in the legislatures of the several states when it comes to striking the proper balance between the rights and responsibilities of health care providers and health care consumers. This is especially true when the momentum for national legislation comes from vested interest, private sector groups who have traditionally abhorred federal action and would predictably oppose such action with respect to any subject matter except when, as in the present example, there is an effort to limit their legal responsibility. It is these very groups whose professional and business affairs have traditionally been the subject matter of state regulation and control.

7. Professionals, including physicians and attorneys, should be held to high standards of conduct and responsibility toward their patients and clients. Proposals which limit such responsibility should be treated as suspect especially when they tamper with institutions and principles long thought to be fundamental to the American system of justice.

As certain earlier witnesses have testified, the medical malpractice issue has various components. Each component deserves separate and careful analysis.

1. The existence of the relatively few physicians who generate a disproportionate amount of insurance payments. Although the figures vary somewhat, studies in Pennsylvania, Florida and California disclose that about one percent of insured physicians generate between twenty-five and thirty-five percent (depending upon the state) of payments to injured victims of malpractice. This Committee has the opportunity to validate, refine or challenge this awesome statistic by inviting the commercial and non-commercial insurance companies to supply this information. They have the data and presumably they would honor a request of this Committee to supply the information. The statistic should not be shocking in the context that the American Medical Association itself concedes that ten percent of America's physicians are impaired in some fashion or other. To its credit, the A.M.A. and other health care groups are increasingly concerned these days about the adequacy of state peer review and disciplinary laws. Daniel F. Creasey, President of the Risk Management Foundation of Harvard Medical Institutions, well summarized the matter in his testimony before this Committee on May 7, 1986 when he said, "The efforts of state medical boards in

the area of disciplining bad doctors range between fairly ineffective to useless. Of the small number of official disciplinary actions taken each year, I would say the vast majority resulted from behavior such as theft, fraud or moral turpitude rather than clinical incompetence."

2. Meaningful risk-management programs will enhance quality health care and reduce the incidents of malpractice.

In his statement to the Committee on May 7, 1986, Richard L. Epstein, Senior Vice-President and General Counsel of the American Hospital Association testified in part that "hospitals can do considerably better in the number, efficiency, and effectiveness of their risk-management programs." Here again, this Committee can access those facts which will help us better understand the extent, efficacy and need for risk-management, risk avoidance and medical treatment safety techniques. Presumably, groups such as the American Medical Association and the American Hospital Association could share that data with the Committee. More importantly, the insurance companies have the data which would, at once, give this Committee the factual wherewithal to determine the recurring scenarios and mistakes which trigger malpractice claims.

3. The operations of the insurance industry should be closely investigated and scrutinized in order to determine the

financial facts in terms of the cost to health care providers and risk classification policies.

This Committee enjoys the opportunity to learn how rates are established for particular groups of health care providers; why there is such a wide disparity in the premium amounts paid by certain physicians and whether those disparities are fair; how much in premium dollars is being taken in and how much paid out; whether as trial lawyers have alleged, the amount of investment income alone earned by insurance companies on their reserves for claims actually or potentially pending exceeds overall all payments for malpractice claims. These facts will tell their own story. Again, we do not presume to suggest what your finding will be but we have a sufficient level of confidence in the result of such an inquiry that we are prepared to go in whatever direction the facts take us.

4. Federal legislation is, at best, premature. As this Committee is aware, the issues which it now addresses are currently high on the agendas in many State Capitols in this country. Laws have been enacted in more than ten states during the past few years. Action is anticipated in yet others. More importantly, the experience of each state widely varies and in this variance, some suppose, resides the beauty of our federal system with its fifty legislative decision-making bodies which

are called upon to strike the balance based on local needs between those who supply products and services and those who consume or use them. Surely, this Committee would wish patiently and thoughtfully to evaluate the results and experience in the states before somehow supposing that in one fell swoop it can wisely pre-empt state law and establish a uniform rule of logic and fairness throughout the land. Here again, I do not suggest what the long-term results will be but, as in other areas which have traditionally been of state concern, it may be worth listening and learning rather than rushing to judgment at the edge of a public relations sword unsheathed by private sector vested interest groups. Proponents of nationalizing the common law through federal proposals are fond of urging the twin rationale of uniformity and the need for immediate relief. The former presumes the wisdom of uniformity in addressing an issue which is as diverse as the fifty states. The latter presumes both that the sky is falling and that inaction or differing action in certain of the states is somehow due to inadvertence as opposed to representing the best current judgment of the elected representatives of the citizens in each community. Proposals for uniform federal "tort reform" legislation have become code words for water reaching its lowest level in terms of protecting health care consumer rights. Is it a mere coincidence that proponents of federal legislation have not found a single flaw in any aspect of American tort law which limits rights of health care consumers. In any event, I invite the Committee not to pre-judge the experience in the states but rather to learn from it on the basis of the accumulated wisdom which we call experience, to reach sound policy judgments in the future.

5. What are the implications of various proposals on health care consumers? It is certainly a legitimate facet of the dialogue on this subject matter to consider the impact of any proposal upon the almost 100% of us who are actual or potential recipients of the health care delivery system and may, so far as any of us are aware, be the victims of negligent health care delivery. The interests of the insurance industry, physicians and trial lawyers are surely secondary to this paramount public interest criterion. Where do health care consumers stand on this issue? How do consumer groups feel about the subject? What do the actual victims of malpractice think? What exactly is the cost per citizen, per patient, per patient visit of the increase in the cost of insurance, and of settlement or verdicts, which we are told are being "passed through" by health care deliverers?

As a percentage of total health care costs or per patient costs, what has been the relative increase over the years of the entire amount paid out in malpractice claims? And just how have the increases in compensation payments in malpractice cases compared with the percentage increases in health care delivery costs? Surely these are some of the pertinent questions that should be asked and answered before health care consumer rights are repealed.

I have not addressed myself to specific proposals for changes in the legal system. I decline to do so, not out of a sense that the right to free access to our courts and fair compensation are indelible birthrights that could not be subject to scrutiny and modification against the test of some overriding public interest imperative. However, as an attorney who came to the profession out of a sense that all citizens, businesses and government, including certainly professionals, are accountable on fundamental notions of responsibility to fairly compensate those injured through neglect or legal fault, I am unable to support a compromise of fundamental rights unless on the basis of a full and fair assessment of the facts, a compelling and overriding public need is documented. This Committee will have the opportunity to get the facts and then to determine whether it wishes significantly to tamper, especially at the federal level, with the rights of America's health care consumers.

The **Chairman**. Mr. Belden, we will turn to you.

Mr. **Belden**. Thank you very much for the opportunity to speak before you.

I am Steve Belden, financial services officer of the Medical Services Division of St. Paul Co. I am an actuary by training, and I know the numbers.

I have with me Sally Frans, who is senior government affairs manager. We are going to split our testimony. Sally is going to give some background on St. Paul, and then I am going to give you some figures on trends in medical malpractice right now.

Sally.

Ms. **Frans**. Thank you, Mr. Chairman.

I will be very brief, and I would just like to provide a short overview of the St. Paul Co.'s perspective on the medical malpractice problem.

We are a property and casualty insurance company and have been in existence for about 133 years. We have been writing medical malpractice insurance for over 50 years, and today our share of the medical malpractice marketplace is almost 20 percent of the national market. That constitutes about one-third of our book of business for the St. Paul Co.

We insure 55,000 doctors; 1,550 hospitals, and thousands of allied health care specialists throughout the United States.

The medical malpractice marketplace has been a volatile one, basically, for the last 10 years. Prior to the midseventies, it was perceived as a fairly calm area in which to do business. At that time, claims began to grow, losses began to grow, and medical malpractice began to be perceived as a risky line of business.

This was, in part, because of the recognition of the long-tail effect of the medical malpractice line, meaning that claims are not paid or settled or even reported until often many years after they have occurred.

At that point, in the midseventies, most of the commercial carriers who constituted most of the marketplace, left the medical malpractice field. In the vacuum that was created by their departure, a number of physicians and medical societies formed their own mutual companies, as well as creation of joint underwriting associations in the State.

Today, I might point out, that the doctor-owned or medical society-sponsored mutual companies constitute about 55 percent of the medical malpractice marketplace. Only 2 percent of the commercial marketplace is in medical malpractice.

What we are seeing today is a disruption in the marketplace. The frequency is growing, which Steve will refer to shortly. Severity is growing. Predictability is a problem. The long-tail effect continues to be a problem, although with the development of the claims-made form in the midseventies, has improved for the companies. And finally, we believe that public expectations of what health care providers can do for their patients now may have exceeded the actual ability that exists. Medical science has done wonders, but it is still not perfect.

And finally, the insurance market has tightened up its limited capacity. And finally, medical malpractice does exist.

What is going on at the Federal level is fairly typical of what we are seeing throughout the United States in the State legislatures. Various State legislatures are considering different tort reform measures, alternative compensation systems, and disciplinary proceedings.

The St. Paul Co.'s position on the tort reform actions that are taking place around the country is, basically, that we have two questions. One is will it be fair, and two what will the cost savings be. It is our perspective, as a company, that it is up to the public policymakers in the individual States or representatives in Congress to make the determination of what sort of a civil justice system is appropriate.

We, the insurance industry, are really a passthrough mechanism, and I think that our duty is to provide input on what various changes might produce, and also to make it clear that whatever civil justice system society wants, the costs will be borne through the insurance system.

I will now turn it over to Steve Belden, who will tell you briefly about our trends in the insurance area.

Mr. Belden. As part of that information what I want to tell you is what is going on with the losses in medical malpractice. Medical malpractice is somewhat different than many other lines of business in insurance in that the trends have been very high, and they have been very high for very long.

When we talk about losses—you should have a set of charts in front of you if you want to refer to that—we split up the losses into two components, the loss frequency, which is how many claims are there, and loss severity, how large are those claims. And when we put them back together, we get what we call pure premium, which is kind of a strange term for the losses that we expect to have on an individual.

The first chart shows the claim frequency. This is our countrywide claim frequency for physicians and surgeons. For St. Paul, countrywide means the 26 States where we have consistently written claims made over the past 8 years. That is basically the Midwest and the Old South.

I am giving you a chart of the number of claims reported in given years per 100 class 1 physicians. I have used a constant exposure base to class 1 physicians, or weighted class 1 physicians, to give you a constant base over time.

Going from 1977 to 1984, the frequency went from 2.7 claims per 100 class 1 physicians to 5.7 claims per 100 class 1 physicians. It more than doubled over that time period. Normally, in lines of business such as auto, you could expect frequency would not increase at all; the number of accidents remains reasonably constant over time, it goes up and down a little, but the frequency for medical malpractice has more than doubled over this time period.

The second chart shows claim severities, and these severities are limited to $100,000, which is our base rate. They are limited to $100,000 so they are more stable over time. Severity went from $11,000 to over $21,000 over that time period, a little less than doubled over that time period of 1977 to 1984. That is greater than inflation.

When you wrap them together, the pure premium went from a little less than $300 per class 1 physician to a little over $1,200 per class 1 physician.

So the losses more than quadrupled per class 1 physician over the time period from 1977 to 1985.

The 1985 figures are consistent with the trends through 1984, so we have been seeing increases greater than 20 percent per year in losses for medical malpractice insurance.

There are a number of other charts that I have included with this that you can look through at your leisure.

The CHAIRMAN. Thank you, I appreciate having your reports.

[The prepared statement of Mr. Belden and responses to questions submitted by Senator Hatch follow:]

STATEMENT OF ST. PAUL FIRE AND MARINE INSURANCE COMPANY

385 WASHINGTON STREET
ST. PAUL, MINNESOTA 55102

BEFORE THE COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

July 22, 1986

INTRODUCTION

The St. Paul Fire and Marine Insurance Company (The St. Paul) is a 133 year old, stockholder-owned, multi-line insurance company. We sell all types of commercial and personal insurance through independent insurance agents in 50 states and the District of Columbia.

The St. Paul has been selling medical malpractice liability insurance since the 1930s. Currently The St. Paul is the largest national provider of medical malpractice insurance with a 1984 market share of 17.9 percent, as measured by A.M. Best Company. 55,000 physicians and surgeons, 1,550 hospitals, and hundreds of thousands of allied health care professionals are insured against medical liability by The St. Paul.

Our medical malpractice liability premium volume in 1985 was $551 million, which represents about 25 percent of our company's total written premium. When combined with ancillary insurance coverage also written through our Medical Services Division for medical-oriented insureds, our total medical-related written premium as of year-end 1985 was $718 million, or about one-third of our total business. Needless to say, insurance sold to the medical community is important to us.

Over the past year, the medical liability insurance marketplace has been in a state of turmoil. Some writers of medical liability insurance have been declared insolvent and are in rehabilitation, while others have withdrawn entirely from certain classes of medical liability coverage. Still others are not aggressively seeking to write new business. Legislators and regulators are responding by closely examining the causes of the current malpractice crisis, reviewing the business practices of medical liability insurers and are searching for solutions to the current crisis.

HISTORICAL PERSPECTIVE ON THE MALPRACTICE SITUATION

THE AVAILABILITY CRISIS OF 1975:

Prior to the mid-1960s, medical liability insurance was a relatively stable line of insurance, but by the early 1970s, it became apparent that this stability was vanishing. The frequency and severity of reported claims began to escalate sharply during that time, a product of society's increased expectations of the medical profession, economic and social inflation, and changes in legal doctrines. Malpractice insurers, at that time primarily multi-line commercial companies, responded by dramatically increasing insurance rates.

As the number and cost of medical malpractice claims began to skyrocket, fewer commercial insurance carriers were willing to risk their capital by writing medical malpractice insurance and an exodus of commercial carriers from the medical malpractice insurance market resulted. This constriction of the marketplace ultimately led to an availability crisis and many health care providers were unable to purchase professional liability insurance at any price.

This crisis led to the creation of new organizations to fill the void left by the departing commercial carriers. Physician and hospital associations formed their own non-profit medical liability companies to solve the availability crisis. These companies, generally fashioned as mutual insurance companies, were established primarily as single-line companies delivering medical malpractice insurance directly to the insured and limiting their writings to a given state.

In addition, joint underwriting associations (JUAs) were legislatively established to make malpractice insurance available to the health care community. Seventeen states legislated JUAs during the mid-1970s, designed as temporary measures, until the market stabilized.

These two phenomena, formation of JUAs and society or association-owned or sponsored companies ultimately relieved the insurance availability crisis of the mid-1970s.

DEVELOPMENT OF THE CLAIMS-MADE FORM:

The 1970s also brought a recognition of the "long-tail" effect of medical liability insurance and the need to develop an insurance product to reduce the effect of the "long-tail."

In medical liability insurance, a time lag exists between the occurrence of an incident and the date a claim is reported and its settlement. These time lags, the "long-tail" of medical liability, determine how much money to set aside to pay for claims (reserves) and make it difficult to accurately set insurance rates.

Until the mid-1970s, insurers sold medical liability insurance in the form of "occurrence" policies. These policies cover all claims resulting from services performed while the policy is in force, regardless of when claims are reported. For example, if a doctor left a sponge in a patient in 1980 and it was discovered in 1990, an occurrence policy would cover the claim under the terms of the 1980 policy -- ten years after the date of the occurrence.

As the number of claims increased, the cost of defending and paying those claims soared, and the awareness of the uncertainty of the "long-tail" grew, many insurers found they could no longer price occurrence policies. In 1975, in response to this problem, The St. Paul introduced the "claims-made" policy form for doctors and hospital liability insurance.

The primary difference between a claims-made and occurrence policy is one of timing -- when claims are covered by a given policy. Claims-made policies cover claims reported while a policy is in force, provided the incident leading to a claim took place after the date when the claims-made coverage was first begun. Although use of the claims-made policy does not eliminate the long-tail, it does help to control its effect. Reserves -- money set aside to pay claims -- are based only on claims reported during the current policy year. As a result, claims-made pricing reflects the most current changes in the legal, social, and economic climate.

Since 1975, The St. Paul has exclusively utilized the claims-made form for physicians and surgeons and hospital medical malpractice liability insurance. Today, the claims-made form is the exclusive policy form for The St. Paul's medical malpractice liability insurance. (Many other malpractice carriers, including physician-owned companies, exclusively utilize the claims-made form.)

THE LATE 1970s AND EARLY 1980s:

Following the availability crisis of the mid-1970s, the composition of the medical malpractice insurance market changed significantly, with a growing dominance of provider-owned or operated mutual companies. By 1983, approximately sixty percent of the medical malpractice insurance coverage was provided by mutual insurance entities which were owned, operated, or sponsored by health care professionals. At that time, there were approximately 20 multiple line writers of medical malpractice, 53 mutual companies and 10 active joint underwriting associations.

As a result of the emergence of these new insurer organizations, there was relative stability in the medical malpractice marketplace during the late 1970s and early 1980s. Despite this calm, insurers remained reluctant to enter the medical malpractice insurance marketplace and the number of insurers engaged in writing medical malpractice liability insurance remained limited.

THE CURRENT MEDICAL MALPRACTICE "CRISIS":

The current medical malpractice market is in a state of flux, characterized by market withdrawal, limited capacity, and major disruptions in reinsurance, restricted underwriting activity, and rapidly rising premiums.

Withdrawal from this market varies geographically and by type of health care provider. Insurers have withdrawn mainly because they lack confidence in their ability to price their products in a rapidly changing claims environment. Lessened availability of reinsurance -- insurance that insurance companies purchase to spread risk -- also has contributed to insurer withdrawal in this market.

Limited capacity -- the amount of risk an insurer is willing or able to accept -- is another characteristic of the medical malpractice marketplace today. In 1984, limits of $100 million were available; by the end of 1985 limits above $10-20 million were difficult to obtain -- or prohibitively expensive. Much of the "capacity crunch" is due to the unavailability of reinsurance.

Many and varied changes in underwriting and coverages are occurring. There has been a mass exodus from the occurrence form of coverage to the claims-made form. In fact, many reinsurers mandate use of the claims-made form for medical liability. Some companies have avoided insuring high risk specialties, such as obstetricians, and some have withdrawn from high-risk geographic areas. Companies are also more carefully reviewing applications for insurance and applicant's claims records.

The St. Paul has temporarily imposed a moratorium on new medical malpractice accounts effective January 1, 1986, countrywide (the moratorium does not apply to additions or changes in our existing accounts). The action was necessitated as a result of the extreme volatility of the medical malpractice marketplace, as well as the unacceptable loss ratios that were experienced in the medical malpractice line. This was also precipitated by a recognition of our very large national medical malpractice market share -- almost 20 percent -- and the need to maintain a balance in our book of business. This action will be reviewed when the company's medical liability results improve and stability is returned to the marketplace.

Poor medical liability results, have led medical liability insurers to seek dramatic increases in rates in recent years. Pricing -- or rating -- of medical malpractice premiums is based on the frequency (the number of claims per 100 doctors or 100 hospital beds) and severity (average cost per claim) of loss. Malpractice rates are calculated to cover the cost of the policy sold and provide a reasonable profit for the risk accepted. As the frequency and severity of loss have increased, malpractice rates have increased as well.

Medical malpractice premium rates for physicians rose an average of 15-20 percent from 1980 through 1983 and increased 25-30 percent in 1984 and 1985. Given the continuing increases in pure premium, and the consistently high loss ratios that have been experienced in medical malpractice, similar rate increases by virtually all medical malpractice insurers can be expected in the future.

Thus, while the crisis of the 1970s was one of availability, the current medical crisis is primarily one of affordability of malpractice insurance. As a result, health care providers have found themselves paying a greater percentage of their income for malpractice insurance.

FREQUENCY AND SEVERITY:

Since 1978, the frequency of claims reported to The St. Paul has increased more than 55 percent -- from approximately 10.7 claims filed per 100 physicians to 16.6 claims per 100 physicians in 1984. Claims against hospitals have also increased from 1.6 claims per 100 beds in 1978 to 3.4 in 1984. Even when you limit claim costs to $100,000, countrywide claim severity (including both paid and reserved claims) increased by 60 percent from 1980-1985. The average cost per claim rose from $13,854 in 1980 to $22,262 by year end 1984.

These two factors are combined actuarially into a third factor -- pure premium. Pure premium is the average loss per insured basic unit. For the most part, this is the amount of premium we must collect to cover loss payments and attorney's fees. The countrywide pure premium jumped more than 150 percent from 1980 to 1984. The average claim cost per insured doctor was $1,476 in 1980 and $3,705 by the end of 1984.

Additionally, the frequency and severity of paid claims has increased dramatically during the past five years. In 1980, The St. Paul paid more than $43 million for physician and surgeon liability claims. In 1984, that amount tripled, rising to more than $122 million. In addition, nearly 9,900 claims remain open at this time.

The number of physicians & surgoens claims closed with indemnity payment by The St. Paul has increased 48 percent during the 1980-1984 period. Claims reported in the calendar year 1980 numbered 1,112 and had risen to 1,643 by 1984. During the same period there was approximately a 20 percent increase in the number of physicians we insured. These are paid claims only which are reported in a number of different years.

The average amount paid on claims (in which no single claim exceeded $1 million) in 1980 was $28,059 and had risen to $56,739 by 1984. Taking all jury verdicts into account, including those in excess of $1 million, Jury Verdict Research, Inc. reports that the average jury awards in all medical malpractice cases has risen nearly 136 percent since 1980 -- from $404,726 to $954,858 in 1984.

In 1984, The St. Paul's medical malpractice losses (including loss expense incurred) have been higher than premiums earned, resulting in a combined ratio of over 128 percent. The combined ratio reflects the ratio of losses and loss expense to earned premiums and a high loss ratio, such as 128 percent, seriously affects an insurer's ability to be profitable. Continued access to our facility is contingent upon a fair return for the risk assumed. Unfortunately, this is no longer the case.

These dramatic increases have driven the need for significant rate growth and led to the current affordability crisis.

PRICING:

Ratemaking methods for malpractice premiums vary by type of health care provider -- physician, health care professional, or health care facility.

Rates for physicians and surgeons are calculated on a "total return pricing" basis, which means investment income is calculated in the actual rating formula. Rates for health care facilities and health care professionals, other than physicians, are calculated by matching premiums collected to losses and expenses and allowing for profit. Investment income is not "explicitly" considered, but is "implicitly" recognized in the premium. Regardless of the method utilized for calculating rates, investment income is clearly reflected in our pricing policy.

In calculating rates for physicians and surgeons, past losses are reviewed and trended into the future to determine the pure premium. To the expected losses are added provisions for expenses, commissions, taxes and profit. That sum is the total amount that must be collected by the combination of premium and investment income.

The amount that will be paid by each of The St. Paul's eight classes of doctors is determined according to their percentage of the losses. Class one doctors pay the lowest rates; class eight doctors the highest. Examples of doctors in class one are general practitioners doing no surgery. Class eight doctors include neurosurgeons -- the specialty that produces the highest losses.

Because loss experience varies by geography, the process is repeated in each state where The St. Paul writes medical liability insurance.

For example, a class one physician in Arkansas pays $1,278 for a one-year million dollar policy. The same physician would pay $3,510 in Minnesota and $8,389 in the Miami area. At the other end, a class eight doctor pays $11,402 for the same policy in Arkansas, $34,855 in Minnesota, and $86,533 in the Miami area (based on December 1985 rates).

The causes of differences between geographic areas is sometimes difficult to pinpoint. Certainly the cost of living is a factor. It costs more to care for an injured party, wages of a disabled plaintiff are greater and lost income of a deceased worker is more in Miami than it is in Little Rock. These factors cause loss severity to be greater in one geographic area than in the other.

An intangible factor is what we can be described as "social inflation" -- the apparently inflated belief that one is entitled to certain results and that society, through a jury, will ensure compensation for an injured party if those results are not achieved. This affects both frequency and severity.

Even the manner in which medicine is practiced appears to be a factor. As medicine moves from a cottage industry to a corporate one, the personal relationships which once deterred patients from suing their doctors may be diminished. Further, with the explosive advances in medical technology and knowledge, patient expectations have increased significantly. This corporate, "high-tech" practice of medicine is more likely to be present in the large urban, tertiary care centers. Accordingly, more urbanized areas tend to reflect greater frequency and severity and, as a result, higher rates for medical malpractice insurance.

As a result of the significant increases in pure premium and the high loss ratios which have been experienced, virtually all malpractice insurers have been forced to significantly increase rates for malpractice insurance to the extent that 25-30 percent can be foreseen for the indefinite future.

CHANGES IN REINSURANCE:

Reinsurance plays a major role in an insurer's capacity to cover large losses. Record losses in insurance and reinsurance have caused many reinsurance companies to withdraw, or limit, their support for volatile coverages like medical liability.

Simply stated, reinsurance is insurance purchased by insurance companies like The St. Paul for protection from large losses. It is a mechanism to spread risk -- just as a homeowner does when purchasing an insurance policy. Reinsurance enables insurers to write policies for higher limits than they could otherwise write and also to write more policies -- this leads to increased capacity -- the amount of insurance an insurer can provide.

Currently a capacity crunch exists in the reinsurance market -- reinsurers have demonstrated less willingness to accept business -- particularly in risky lines. As a result, lower limits (the maximum amount that a reinsurer will pay for a loss) are available. When reinsurance is unavailable, insurers have a decreased ability to write new business because capacity is absorbed by current customers.

A major factor influencing the reinsurance shortage is the American civil justice system. Patients often expect perfect medical results from today's high level of medical technology. When results fall short of expectations, patients look to the legal system for recompense -- often with successful results. In 1980, the average malpractice verdict was $404,726. By 1984, that figure had risen to $954,858. Although relatively few cases reach a verdict, settlement trends are similar. When these amounts exceed the limits that primary insurers pay, reinsurers step in.

Reinsurers predict that the shortage will continue and available reinsurance will rise in price until predictability is returned to the American tort liability system.

INCIDENCE OF MALPRACTICE:

While malpractice claims against doctors, hospitals, and other health care providers are rising in number and cost, there is no evidence that these increases reflect a rise in the incidence of medical malpractice. While the number of claims reported to The St. Paul has increased steadily since 1978, this deterioration does not measure the incidence of patient injury due to negligence. Experience has shown that up to two-thirds of these claims are eventually closed with no indemnity payment. Even when claims are closed without an indemnity payment, considerable legal and other expenses may be incurred.

The increased incidence of claims has been attributed to other causes than diminished quality of health care. In fact, the high quality and sophistication of health care today has led to ever-increasing consumer expectations which cannot always be met.

Although there is no doubt that some patient injuries do occur as a direct result of negligence on the part of health care providers, the key question remains as to how many injuries are actually the result of negligence.

This issue was the subject of intensive study during the 1970s, crisis, but no definite answer exists. A study prepared for the HEW Commission on Medical Malpractice in 1973 estimated that 7.5 percent of all patients discharged from a hospital suffered iatrogenic (provider-induced) injuries and 30 percent of those were believed to be due to some negligence which could be demonstrated. The study noted that only 1.7 percent of those patients filed malpractice claims.

Why has frequency grown at such a rapid rate? There are many factors involved in the recent increases in claim frequency. Many are not tied to a lack of quality health care, but actually result from significant improvements in these services. Health care, as an industry, has expanded to the point where it is accessible to all and advancements in technology are well publicized. This has led to increased expectations by consumers for a level of health care that is not attainable by many local health care systems. Combined with these expectations is easy access to a legal system, which through advertising, and wide publicity about windfall jury verdicts may have increased the motivation of individuals to sue.

Subjectively, scrutiny of the quality of care has improved over the past decade. Prior to the 1970s "crisis," industry standards for ongoing review of the quality of care provided for patients were limited. Medical staffs have traditionally had some role in reviewing and critiquing patient treatment based on outcome, but this was more an academic exercise than a quality assurance mechanism.

Over the past ten years, quality assurance and risk management have become essential elements of the health care industry. Hospitals and individual providers have implemented these programs independently or in response to mandates of regulatory bodies, the Joint Commission on Accreditation of Hospitals (JCAH) and pressure from insurers.

The evolution of formal risk management and quality assurance procedures have allowed for the development of programs and informed medical staffs which enable an organization to verify the competency of staff members on an ongoing basis. Problems are identified and can be addressed prior to an adverse occurrence if the program functions efficiently.

Sound risk management and quality assurance efforts can be effective in reducing the number of claims related to quality of care. These programs must, however, have complete commitment from hospital management and medical staff. The quality of care must be assessed by medical staff and recommended improvements implemented. Effective risk management and quality assurance programs can help reduce patient injuries and provide a level of documentation necessary to improve defensibility against claims which may still occur.

THE TORT SYSTEM:

As has been demonstrated, the medical liability system is driven by the interaction of the legal system, the health care system, the insurance industry and the medical consumer. In addition to growing frequency and severity of claims, the American liability system has undergone dramatic and unpredicted change, creating liabilities not anticipated at the time policies of insurance were drafted and underwritten. There also appears to be an increased willingness to sue and greater ability to do so. Insurance underwriters must predict, not only the conduct of their insureds, but also changes in our scientific, social, economic and legal systems. Unfortunately, given the current legal environment, the ability to predict loss has been seriously hampered.

Clearly, a goal of our civil justice system must be to fairly compensate those parties who are truly injured as a result of another person's negligence. Some question whether our civil justice system is achieving that goal. Increased expectations of the public have extended to our legal system and in many cases there is a belief that any unintended adverse result should be compensated -- despite traditional legal theories of negligence requiring actual wrongdoing and a causal connection between the negligent act and the injury. The liberalization of the doctrine of liability has certainly increased the number of medical malpractice awards, as well as their severity.

Rapidly changing developments in the health care delivery system have also had a major effect on the medical liability market. Sophisticated medical technology has led to new legal problems that insurers have found difficult to predict.

Additionally, the legal and administrative expenses associated with providing liability coverage (actually part of the insurance product) have increased in recent years with such expenses now constituting approximately 30-35 percent of total loss payments.

The dramatic changes in the tort system, coupled with its lack of predictability, have led to much instability in the medical malpractice marketplace.

PROPOSED TORT REFORM MEASURES:

Virtually every state legislature in the country, as well as Congress, has recently undertaken a review of its tort liability system to determine what, if any, modifications should be made which would help reduce the number of lawsuits instigated, more fairly compensate injured parties, reduce the cost of malpractice insurance, restore predictability, and return the concept of fault to the courtroom. Legislators, regulators, and governors are searching for changes in the civil justice system to serve the interest of all concerned parties -- the public, health care providers, insurance companies, and the legal community. Many legislatures have enacted tort reform measures and it is expected that this trend will continue.

The following measures have most frequently been proposed as recommended changes to the tort system:

- Caps on non-economic damages;
- Elimination or modification of the collateral source rule;
- Limitations on attorneys' contingency fees;
- Penalties for bringing frivolous lawsuits;
- Modification of statutes of limitation;
- Elimination of joint and several liability;
- Requirements of periodic payments or structured settlements;
- Specification of elements of damage;
- Strengthened disciplinary procedures;
- Strengthened state of the art defenses;
- Strengthened standards of care defenses; and
- Elimination or modification of punitive damages allowable.

When scrutinizing the constitutionality, effectiveness, or desirability of changes in the tort system, legislatures and courts have historically focused on two key issues:

First, will the proposal save money?

Second, will it be equitable to all elements of society?

In balancing those two concerns, which are not always compatible, the key test has been whether those injured, and society as a whole, have been provided with a quid pro quo. The St. Paul believes that only society as a whole, through its elected representatives, can make that determination.

The insurance industry can, however, advise society and legislators whether a given change will reduce the cost of the system and what other impacts on society would likely occur. Since The St. Paul is in the asset protection business, we are in a special position to provide available information to help evaluate the major changes taking place in the reparations system and the impact of those changes on both benefits and costs. As the nation's leading insurer of health care providers, The St. Paul has a unique understanding of how the reparation system works for this line of business. We stand ready to share our knowledge and serve as a constructive advisor to policymakers concerned about the cost of the civil justice system. However, even with our experience and data, it is not possible to estimate, with any degree of precision the potential cost savings for any suggested change in the tort system.

TORT REFORM SAVINGS:

A number of studies have been conducted, in recent years, detailing the potential savings which might be achieved from enactment of various tort reform measures. The St. Paul is extremely concerned that these studies will be improperly interpreted and public expectations unfairly raised.

The following caveats should be kept in mind when reviewing any tort reform cost savings analyses:

- Most costs savings analyses have focused on the effect of changes in the tort system on the severity of claims. These analyses have not, however, measured the effect of changes on claim frequency. Absent any change in frequency, expected rate increases will only be slowed, not reduced. In addition, modifications in the behavior of individuals, as well as society as a whole, have not been considered in calculating cost savings.

- The proposed reforms analyzed deal only with court awards. It is difficult to presume that those estimated savings would translate proportionally to cases settled before going to court. As indicated earlier, the vast majority of claims are settled prior to trial. In light of pressure to quickly dispose of cases by settlement, many perceived savings on court awards would not necessarily translate to other settlements.

- May tort reform measures will be subjected to court challenges which may take years to conclude. Only when these reforms have been successfully defended will they take effect and it will be several additional years until any impact on cost may be realized. Moreover, reforms which have been successfully defended in one state may not be upheld in others -- state courts and constitutions vary widely.

- Because there are relatively few claims each year with non-economic damages in excess of $250,000, restricting non-economic damages to this amount will have limited effect on costs. Limits on non-economic damages may, in time, have an effect on the willingness of individuals with limited economic losses to pursue claims in the hope of recovering windfall non-economic damages. There is some concern that limitations on non-economic losses will lead juries to over inflate economic damages to compensate for the reduction in non-economic awards. Finally, there is a possibility that caps on non-economic awards may ultimately become a target, rather than a ceiling, for awards.

- Insurers have used the concept of structured settlements for nearly ten years and continue to maintain that, through the purchase of an annuity or some other long-term funding instrument, structured settlements are an effective means of providing for the maintenance of an injured individual while

> potentially reducing payout costs to the system. We are, however, concerned about proposals which would mandate the use of structured settlements in all situations. Our concern has been that structured settlements, mandated before trial, might limit our ability to innovatively handle claims during the settlement/negotiation process. Proposals which would specify the investment vehicle, payout patterns, etc. would further limit the ability to utilize structured settlements. Finally, many legislative proposals mandate the use of structured settlements for court awards over a certain dollar amount. Such proposals may have little, or no, impact on settlements and, as a result, the cost savings to the system which are realized may be limited.

In the area of medical liability, The St. Paul recognizes that our many years of being the leading writer of this coverage means we should be the primary source of information. We must stress that, even with our experience and data, it is not possible to precisely estimate the potential cost savings for every suggested change in the tort system. We are attempting to improve our ability to do so. In the meantime, while available data may not always permit us to quantify impact on cost, logic will tell us that certain changes are likely to reduce claims cost, while others will not provide any significant savings. In any event, insurance rates cannot be reduced until changes have been implemented and, most important, a reduction in loss costs has actually occurred. Resulting savings will ultimately be reflected in lower rate increases as our experience improves.

CONCLUSION

As is evident, continued turmoil in the medical liability market has again become a focal point for public attention. The plaintiffs' bar has attacked the integrity of health care providers and those who insure them. The health care industry threatens to change practice patterns and to withhold services unless their demands are met. Many health care providers believe our civil justice system is neither "civil" nor "just". Most insurers have withdrawn from the medical liability line of business entirely. Others who remain have severely restricted capacity. Health care consumers have frequently found themselves caught in the middle of this dilemma.

Against this backdrop, The St. Paul commitment to the medical malpractice marketplace remains strong -- our current market position is evidence of that commitment and responsiveness. We recognize that there are no easy solutions to the current medical liability crisis and we offer our expertise and assistance to you as you consider various solutions to the crisis.

Thank You.

St. Paul Fire and Marine Insurance Company
385 Washington Street, St. Paul, Minnesota 55102
Telephone (612) 221 7911

The St Paul
Property & Liability
Insurance

October 2, 1986

The Honorable Orin Hatch, Chairman
Committee on Labor and Human Resources
Washington, DC 20510

Dear Senator Hatch:

In response to your follow-up questions from the medical malpractice hearings on July 22, 1986, The St. Paul Companies would like to make the following observations. I've reiterated each of your questions in the order that you asked them and my answers follow them.

1. At our first hearing on the malpractice insurance crisis, we heard from doctors who, through no fault of their own, had to curtail their practices because they could no longer afford malpractice insurance, and we heard from consumers who had lost access to needed medical services because their doctors had cut back their practices. Also, we've heard of the need for tort reform and no need for such reforms and that insurance companies are the problem. So let me determine at the outset whether you feel that a genuine problem exists--at least in perception if not substantively?

A. Over the past year, the medical liability insurance marketplace has been in a state of turmoil. Some writers of medical liability insurance have been declared insolvent and are in rehabilitation, while others have withdrawn entirely from certain classes of medical liability coverage. Still others are not aggressively seeking to write new business.

Withdrawal from this market varies geographically and by type of health care provider. Insurers have withdrawn mainly because they lack confidence in their ability to price their products in a rapidly changing claim environment. Lessened availability of reinsurance also has contributed to insurer withdrawal.

Limited capacity--the amount of risk an insurer is willing or able to accept is another characteristic of the medical malpractice marketplace today. In 1984, limits of $100 million were available; by the end of 1985 limits above $10-20 million were difficult to obtain or prohibitively expensive. Much of the capacity crunch is due to the unavailability of reinsurance.

Property and Liability Affiliates of The St. Paul Companies Inc. | St. Paul Fire and Marine Insurance Company | St. Paul Mercury Insurance Company
The St. Paul Insurance Company | St. Paul Guardian Insurance Company | The St. Paul Insurance Company of Illinois

Many changes in underwriting and coverages have also occurred. There has been a mass exodus from the occurrence form of coverage to the claims-made form. Some companies have avoided insuring high-risk specialties, such as obstetricians, and some have withdrawn from high-risk geographic areas. Companies are also more carefully reviewing applications for insurance and applicant's claims records.

The St. Paul has temporarily imposed a moratorium on new medical malpractice accounts, effective January 1, 1986, countrywide (the moratorium does not apply to additions to or changes in existing accounts.) The action was necessitated as a result of the extreme volatility of the medical malpractice marketplace, as well as the unacceptable loss ratios that were experienced in the medical malpractice lines. This was also precipitated by a recognition of our very large national medical malpractice market share and a need to maintain a balance in our book of business. This action will be reviewed when the company's medical malpractice liability results improve and stability is returned to the marketplace.

Poor medical liability results, have led medical liability insurers to seek dramatic increases in rates in recent years. Pricing--or rating--of medical malpractice premiums is based on the frequency and severity of loss. Malpractice rates are calculated to cover the cost of the policy sold and provide a reasonable profit for the risk accepted. As the frequency and severity of loss have been increased, malpractice rates have increased as well.

Medical malpractice premium rates for physicians rose a average of 15-20 percent from 1980 to 1983 and increased 25-30 percent in 1984 and 1985. Given the continuing increases in pure premium, and the consistently high loss ratios that have been experienced in medical malpractice similar rate increases by virtually all medical malpractice insurers can be expected in the future.

Thus, while the crisis of the 1970's was one of availability, the current malpractice crisis is primarily one of affordability of malpractice insurance. As a result, health care providers have found themselves paying a greater percentage of their income for malpractice insurance.

The medical liability system is driven by the interaction of the legal system, the health care system, the insurance industry, and the medical consumer. In addition to growing frequency and severity of claims, the American liability system has undergone dramatic and unpredicted change, creating liabilities not anticipated at the time policies of insurance were drafted and underwritten. There also appears to be an increased willingness to sue and greater ability to do so. Insurance underwriters must predict, not only the conduct of their insureds, but also changes in our scientific, social, economic, and legal systems. Unfortunately, given the current legal environment, the ability to predict loss has been seriously hampered.

A goal of our civil justice system must be to fairly compensate those parties who are truly injured as a result of another person's negligence. Some question whether our civil justice system is achieving that goal. Increased expectations of the public have extended to our legal system and, in many cases there is a belief that any unintended adverse result should be compensated--despite traditional legal theories of negligence requiring acutal wrong doing and a casual connection between the negligent act and the injury. The liberalization of the doctrine of liability has certainly increased the number of medical malpractice awards, as well as their severity.

Rapidly changing developments in the health care delivery system have also had a major effect on the medical liability market. Sophisticated medical technology has led to new legal problems that insurers have found difficult to predict.

Additionally, the legal and administrative expenses associated with providing liability coverage have increased in recent years, with such expenses now constituting approximately 30-35 percent of total loss payments.

The dramatic changes in the tort system, coupled with its lack of predictability, have led to much instability in the medical malpractice marketplace.

As is evident, continued turmoil in the medical liability market has become a focal point for public attention. The plaintiffs' bar has attacked the integrity of health care providers and those that insure them. The health care industry threatens to change practice patterns and to withhold services unless their demands are met. Many health care providers believe our civil justice system is neither "civil" nor "just." Most insurers have withdrawn from the medical liability lines of business entirely. Others who remain have severly restricted capacity. Health care consumers frequently find themselves caught in the middle of the dilemma.

2. Is there any action this committee can take to encourage a more effective disciplinary system for malpractice?

A. Over the past ten years, quality assurance and risk management have become essential elements of the health care industry. Hospitals and individual providers have implemented these programs independently or in response to mandates of regulatory bodies, the Joint Commission on Accreditation of Hospitals and pressure from insurers.

The evolution of formal risk management and quality assurance procedures have allowed for the development of programs and informed medical staffs which enable an organization to verify the competency of staff members on and ongoing basis. Problems are identified and can be addressed prior to an adverse occurrence if the program functions efficiently.

Sound risk management and quality assurance efforts can be effective in reducing the number of claims related to quality of care. These programs must, however, have the complete commitment of hospital management and medical staff. The quality of care must be assessed by medical staff and recommended improvements implemented. Effective risk management and quality assurance programs can help reduce patient injuries and provide a level of documentation necessary to improve defensibility against claims which may still occur.

We believe it is imperative that your committee work with the medical community as you develop appropriate risk management and quality assurance initiatives.

3. Should the tort law of joint and severable liability be addressed in my proposed legislation, and if so, what should be done about it?

A. When scrutinizing the constitutionality, effectiveness, or desirability of changes in the tort system, such as elimination of joint and several liability, legislatures and courts have historically focused on whether the change will save money and whether it will be equitable to all elements of society. In balancing these two concerns, which are not always compatible, the key test has been whether those injured, and society as a whole, have been provided with a quid pro quo. The St. Paul believes that only society as a whole, through its elected representatives, can make that determination.

When considering any tort reform changes and what potential savings might ensue we hope that you will keep in mind the caveats identified in our written statement on page 12.

4. You state that up to two-thirds of the claims against health care providers insured by St. Paul are closed with out indemnity payment. Would it be fair to say that this indicates that a great number of frivolous claims are being filed against the medical profession?

A. Not all claims that are closed without payment are frivolous. Most claims are closed after further investigation reveals that no negligence has occurred. Similarly a number of claims are successfully defended through the actual trial stage.

5. You state that considerable legal and other expenses can be incurred even when a claim does not result in payment. What, if anything, can be done to discourage the filing of frivolous claims?

A. We believe this question is one that addresses self-policing of the legal community and is best answered by the legal community itself.

6. In our field investigation, a number of doctors and other health care providers told us that they successfully urged their insurance carriers to pay claims that they regarded as frivolous rather than expose them to the publicity of a lawsuit, even when they thought they could win the suit. Would you say this happens often in the insurance industry?

A. We do not believe this happens often. The decision whether to settle a claim is one that is made by the insurer after careful investigation of the facts to determine whether there is any basis for liability and the extent of that liability.

7. I would characterize your prepared testimony as being rather skeptical with regard to tort reform. Are there any measures other than tort reform that you think could result in greater affordability of medical malpractice insurance? Or are we faced with a crisis for which you offer no practical solution?

A. Although The St. Paul has neither advocated not opposed any changes in the civil justice system, we do believe that certain changes are likely to reduce claims cost, while others will not provide any significant savings. Changes in the tort system or improvements in the delivery of health care which will lead to a reduction in the frequency and severity of claims will ultimately be reflected in lower rate increases as experience improves.

8. In 1985, you state that the total medical related premium paid to St. Paul's was 718 million dollars. What assumption for net profits were made when calculating those premiums as well as for inflation and income from invested reserves and other corporate investment?

A. The bulk of the premium written in 1985 was written at rates that contemplated a 4 percent profit factor. Interest income was projected at 10% per annum on funds held, for a total of 30% of the total premium in the policy. That means that we expected to pay 30% of our loss dollars and expenses out of investment income. The anticipated profit mentioned earlier was after the 30% investment income was earned.

We did not project inflation explicitly, but we did project a trend in average loss cost per doctor. This trend has been averaging about 25% per year over the last 5 years. We have projected that this trend will continue.

Please note that these are only targeted profits and investment income. The true results have been much worse than the projections. The losses have been worse than projected, so we are not getting the anticipated profit. In addition, because of the interest rate drops and the larger than anticipated loss payments we are not earning the anticipated interest income.

These parameters have been changed in recent rate filings to reflect current conditions. The target profit is now 5½%. Projected interest income has dropped to a 6.75 rate per year on funds held, or 18.5% of the premium over the life of the policy. The trend is still up around 25%.

9. In your prepared statement you indicate a moratorium on new accounts because of an unacceptable loss ratio. What is that loss ratio and what would be acceptable?

A. Our loss ratio was approximately 129 percent in 1984, and 115 percent in 1985. An acceptable loss ratio varies in relation to our investment income, but generally is about 85 percent.

10. You state that the average claim paid per insured doctor was $1,476 in 1980 and $3,705 in 1984. What was the average premium per insured doctor in those years?

A. The average paid premium figure in 1980 comparable to the loss information I have given you is $1,685. In 1984, that figure is $3,316.

11. You point out the difficulties in re-insurance. What should be done to remedy this problem?

A. The reinsurance industry, like primary insurers, suffered extremely high losses in 1984 and 1985. They have been increasing their rates to levels that are actuarially sound.

12. What are your impressions of the medical malpractice insurance legislation (copy attached) introduced by Senator Gore and discussed at the July 22, 1986, hearing of the Senate Labor and Human Resources Committee?

A. Although The St. Paul is generally supportive of efforts to strengthen and improve professional review activities of health care entities, we are concerned about the significant reporting burden imposed by S. 2677. Reporting each and every paid claim will be very burdensome and may result in the reporting of extremely small, insignificant claims. A more reasonable minimum limit should be included. We are also concerned about potential liability from reporting the required information, despite the immunity language.

Please let us know if we can be of any additional assistance. Thank you.

Sincerely,

Stephen A. Belden
Financial Services Officer

The St Paul

The CHAIRMAN. Mr. Hunter, let us turn to you.

Mr. HUNTER. As you can see from the chart, the insurance business generally is a cyclical profitability business. The chart is reproduced in the testimony which you will put in the record, as I heard you say.

Ten years ago when I was Federal Insurance Administrator under President Ford, I appeared before the Health Committee of Senator Kennedy and told them that the insurers had engaged in panic-pricing and that the crisis which they were blaming on the courts was in fact a self-inflicted wound, based on overzealous underwriting, in medical malpractice and product liability and the other lines.

Our studies of that crisis show that the resulting price increases led to major profits and easing of the market. Just this morning, the major price increases that have occurred in the last years have led to an easing of the market. The Nurse Midwives announced this morning that they have gotten insurance coverage from a consortium of insurance companies.

In 1985 dollars, medical malpractice premiums were $2.6 billion in 1976 and dropped to $1.8 billion by 1982, and are now at $3.4 billion. Over the entire time, premiums rose in constant dollars at a real rate of 3 percent per year.

That is not a crisis. Looking at just the 1982 to 1985 level, however, premiums rose at more than 25 percent per year, because they were catching up for their previous price-cutting activities.

Both private insurers and doctor-owned insurers engaged in this overoptimism, in part because doctor-owned insurers are pretty much swung by the swings of the insurance industry, particularly by the reinsurers who reinsure them.

The costs of all liability-paid claims have been rising at a level slightly above inflation but interestingly at a slower rate than workers' compensation insurance, a nofault system. When adjusted for such phenomena as expanding life expectancy and changing workplace demographics—for example, more women working—there is no real growth in the average claim size in overall liability, and a modest 1 to 2 percent real growth for medical malpractice.

NICO considers that the medical malpractice crisis, like that in all of liability insurance, is a self-inflicted wound by the insurance industry, and that even the doctors' mutuals are being swung by these cycles because of their reinsurance connections.

In New Jersey, the doctors' mutual, has complained that the reinsurers are forcing them to use claims-made policies over their objections. In Maryland, they have claimed that the Ob-Gyn rates had to be higher than their own actuaries said were necesary because Lloyd's of London made them do it.

There is no innovation from the doctors' mutuals. They are very much like normal insurance companies. The need is insurance reform, not tort reform, and I have attached to my testimony a list of such things as bringing the insurance industry under the antitrust laws by amending the McCarran-Ferguson Act which exempts insurance from the antitrust laws and establishing a Federal office to monitor the insurance industry to get control of these cyclical patterns; a repeal of the insurance industry's exemption from Federal Trade Commission jurisdiction.

I also think that some tort reform is necesary that deals with structural reform. I think the lawyers are taking too much out of the system, but not just the plaintiffs' lawyers; I think both sides need to have some controls. I think there should be penalties for frivolous suits, but also penalties for frivolous defenses, objections and the like. They are also listed in my testimony.

Very importantly is the question of allocation. According to HHS just this morning, the Nation's health care costs about $390 billion a year in 1984. The 1985 premiums are $3.4 billion. Medical malpractice, if you put a cap of zero, would only reduce the health care costs by less than 1 percent.

Medical malpractice is not a huge part of health care costs; it is a very tiny part of health care costs.

The dichotomy is we have a low-cost system where there is a high cost of certain specialties, such as Ob-Gyns. And the question is why, and I think we need to get into that in some depth at some point.

We have sort of a pyramid in the medical system. If I have a bad back, and I go into the base of the pyramid, I enter and talk to my general practitioner, where there are hundreds of thousands of them. But the worse my back is, the higher I rise in this pyramid toward the neurosurgeon specialists, and the fewer doctors there are to bear the costs of an adverse outcome or a sneeze that might occur at the wrong time during surgery.

That pyramid analogy is very important, because the higher the risk, the fewer that are there to bear it. We need to find ways to change that, and we need to find ways, I think, to have some of the costs borne by the hospital that gives the doctor the privilege, so that there is an economic incentive for that hospital not to give privileges to people who are incompetent, because one thing we do know from our studies is that incompetent doctors are not kicked out and delicensed by States.

Finally, the question is data. We are 18 months into the crisis with no data. How much is paid out in claims versus how much is taken in. We do know over the last 10 years, they have taken in $150 million and paid out $50 million.

However, we do not know things like how much is paid for noneconomic damages, how much is paid for medical, how much is paid for punitive, how much is paid for wage loss, how much was the victim's economic damage.

When I was Federal Insurance Administrator, I supported national no-fault auto insurance, a very serious tort reform, and I got President Ford to support that. But we had the data before us; we knew what we were doing. We knew how victims fared, and we knew what was wrong with the system.

I have to oppose caps on noneconomic damages and things like that without the data, because I do not think it is appropriate to take away the rights of citizens without the analyses. These data reside in the files of St. Paul and these other companies, and they are just refusing to come foward with them.

If you had the data, you could see what was wrong with the system, and you could see if we put a cap on, say, noneconomic, how much rates would fall. It is a very reasonable question—how much would rates fall if we did this.

I think to undertake major change in victims' rights without data is like doing surgery without an x ray—legislative malpractice, I think.

Thank you, sir.

The CHAIRMAN. That is quite provocative. Thank you.

[The prepared statement of Mr. Hunter and responses to questions submitted by Senator Hatch follow:]

TESTIMONY OF

J. ROBERT HUNTER
PRESIDENT
NATIONAL INSURANCE CONSUMER ORGANIZATION

1. The insurance crisis is due primarily to the cyclical nature of the insurance industry.

Insurance companies cut their prices when interest rates, and thus their income from investing the premiums they collect, are high; they raise their prices when interest rates, and thus investment income, are low. They overreact at both the top and the bottom of the cycle. (See Chart 1.)

Wall Street understands the insurance industry cycle: while the price of insurance rises and falls, insurance stock prices just keep on rising. For example, since 1975 the property/casualty insurance stock index rose almost 500%, while the Dow Jones Industrial Average did not even double. And during 1985, as insurers complained of their dire financial condition, the property/casualty index rose by 50%, almost twice the rise in the Dow. (See Chart 2.)

2. The special privileges enjoyed by the insurance industry are largely responsible for the insurance cycle. For example:

A. The insurance industry is exempt from the antitrust laws. This allows insurance companies to agree to raise their prices without fear of antitrust prosecution. Executives in other industries who act in concert to raise prices can go to jail.

B. The insurance industry is exempt from federal regulation. In all other cases, when the federal government exempted an industry from the antitrust laws it substituted regulation for antitrust enforcement, as it did with trucking, railroads and utilities. The insurance industry is unique: that it is exempt from both antitrust enforcement and federal regulation, leaving the federal government impotent to deal with the dramatic price rises, mid-term cancellations and refusals to insure at any price so prevalent today.

C. The insurance industry is protected from competition by state regulation. Many state laws prohibit businesses, as well as consumers, from joining together to buy insurance at a lower rate, and state and federal laws prohibit other financial institutions from selling insurance.

D. The insurance industry is exempt from Federal Trade Commission scrutiny. In 1979, after the FTC published a study critical of the life insurance industry, Congress prohibited the FTC from ever again studying -- let alone prosecuting -- any sector of the industry.

3. The property/casualty insurance industry is exempt from federal taxation.

According to the General Accounting Office, the property/casualty insurance industry earned a profit of $75.2 billion during the period 1975-84, yet paid no federal income tax. The industry's tax exemption is due primarily to three insurance industry accounting privileges: the most significant such privilege is the provision allowing insurance companies to take a tax deduction for both the amount they pay out in the tax year and the amount they estimate they will pay out in the future. This amount is frequently wildly overestimated and consequently taxable income is substantially underestimated.

While the federal tax exemption for property/casualty insurance is not a direct cause of the insurance crisis, it does illustrate the extent to which the insurance industry is not subject to the same constraints to which other American businesses are subject.

4. The failure of the United States to regulate foreign reinsurance companies contributes to the insurance crisis.

Reinsurance is insurance for insurance companies: the insurer pays the reinsurer a premium and the reinsurer agrees to share the risk with the insurer. Most reinsurers are foreign. By far the dominant force in the reinsurance market is Lloyd's of London, which has dramatically raised the reinsurance premiums it charges many primary insurers and has pulled out entirely from many markets. It has also been racked by scandals. Because Lloyd's is not subject to federal regulation, American insurers have little recourse when Lloyd's raises its rates.

CHART 1

THE INSURANCE INDUSTRY CYCLE

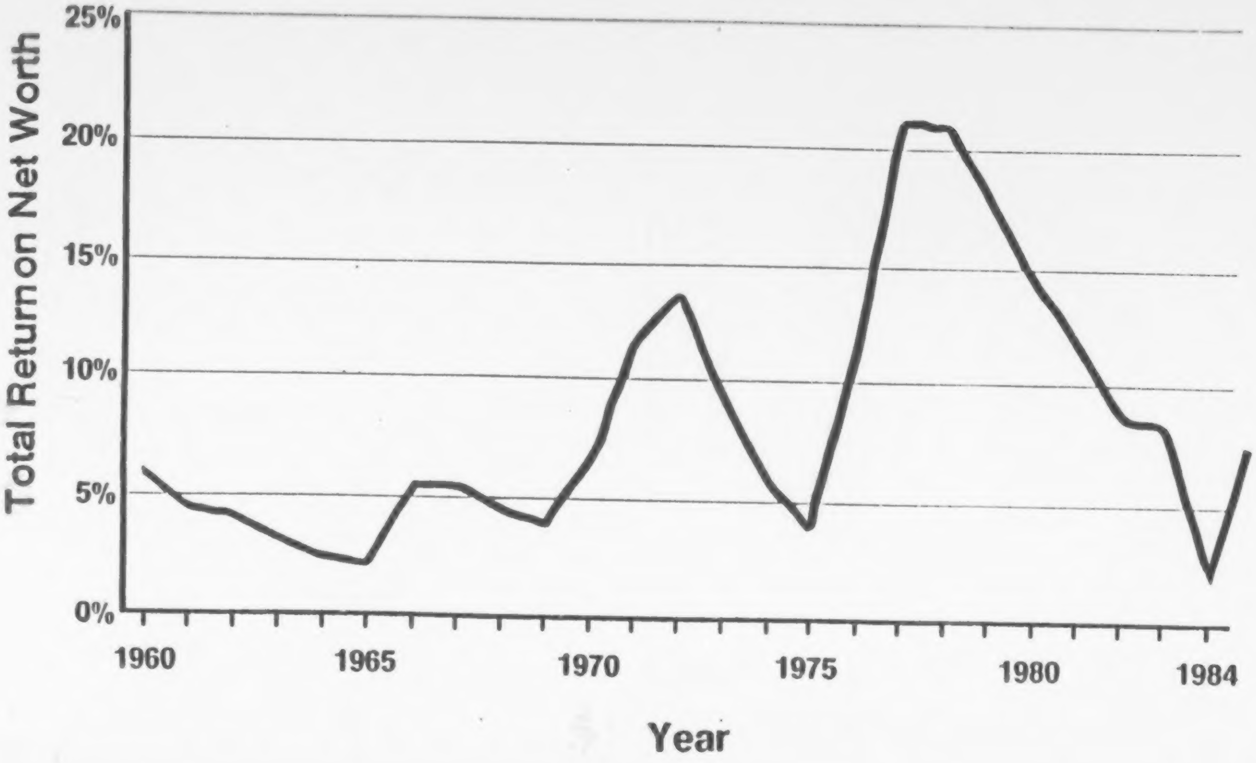
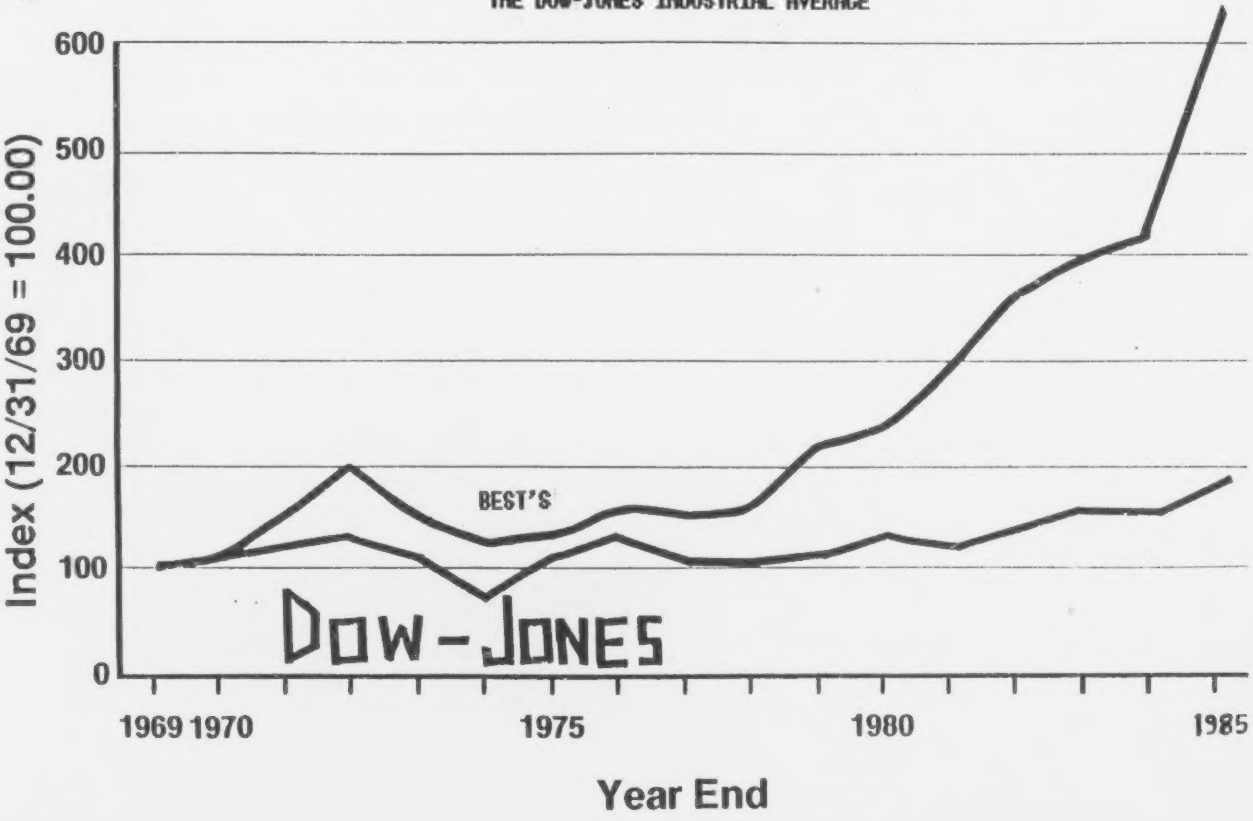


CHART 2

BEST'S PROPERTY/CASUALTY STOCK INDEX
V.
THE DOW-JONES INDUSTRIAL AVERAGE



NATIONAL INSURANCE
CONSUMER ORGANIZATION

FACT SHEET ON MEDICAL MALPRACTICE INSURANCE

I. MEDICAL MALPRACTICE INSURANCE COMPANIES ARE PROFITABLE.

A. Between 1976 and 1983, medical malpractice insurance companies earned an average of 22% on net worth -- almost double the average for all industries -- as the following table shows:

PERFORMANCE OF US MEDICAL MALPRACTICE INSURERS

Year	Earned Premiums	Rate of Return
1976	$ 1.2 B	45%
1977	1.3	54
1978	1.4	31
1979	1.4	24
1980	1.3	21
1981	1.4	9
1982	1.5	-1
1983	1.8	6
Average	$11.3 B	22%

Source: National Association of Insurance Commissioners Report on Profitability, by Line, by State. (1983 data is most recent data available.)

Rate of return calculated by multiplying operating profit, as reported by NAIC, by 2, and then adding in investment income on surplus at an assumed after-tax yield as follows: 1976, 5.0%; 1977, 5.5%; 1978, 6.0%; 1979, 6.5%; 1980, 7.0%; 1981, 7.5%; 1982 8.0%; 1983, 8.5%.

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B. *Between 1978 and 1983, US medical malpractice insurers took in more than 6 times as much as they paid out, according to A.M. Best's.* They earned $7.344 billion in premiums and $1.761 billion in investment income, for a total of $9.105 billion, but paid out only $1.465 billion in claims.

C. *When insurance companies say they had an "underwriting loss" in 1985, that does not mean that they actually paid out more than they took in in 1985; rather, it means that they estimate that they will eventually pay out -- as long as it takes to resolve all claims against policies in force in 1985 -- more than they took in in 1985.* As a result, even when companies have an "underwriting loss" they almost always take in much more than they pay out.

Since 50% of malpractice claims are not paid until about 8 years after the policy is written, the underwriting loss figure is particularly misleading for medical malpractice insurance: on the one hand the insurance company invests and earns interest on the money it keeps, while on the other hand it deducts the entire amount for both accounting and tax purposes in the first year. As a result neither the amount the company estimates it will pay out in the future nor the interest earned thereon is ever taxed. (This is the main reason why, according to the GAO, property/casualty insurance companies had net gains of $75.2 billion between 1975 and 1984 yet paid no federal income tax -- and even got a $125 million tax refund from the government.) *See*, U.S. General Accounting Office, Tax Administration: Information on How the Property/Casualty Insurance Industry is Taxed (Oct. 1985).

II. ALTHOUGH THE TOTAL COST OF MEDICAL MALPRACTICE INSURANCE IS RELATIVELY LOW -- ABOUT 1% OF TOTAL HEALTH CARE COSTS -- THAT COST IS POORLY ALLOCATED. DOCTORS IN HIGH RISK SPECIALTIES ARE VICTIMS OF THIS MISALLOCATION.

A. *Good doctors -- who are the overwhelming majority -- subsidize bad doctors.* Although study after study has shown that a small percentage of doctors is responsible for a large percentage of malpractice, doctors who have never been sued pay the same premium as a doctor found liable for malpractice several times. *See*, *e.g.*, Michigan Report on the Liability Crisis at 11 (1985) (19.3% of doctors accounted for 72.2% of claims; 58.1% had no claims); Florida Insurance Commissioner, Closed Claims Study of Medical Malpractice Insurance, 1975-82 (1983) (0.7% of doctors accounted for 24% of claims; one doctor for 31 claims); S. Ferber & B. Sheridan, "Six Cherished Malpractice Myths Put to Rest," 52 Medical Economics 150 (1975) (0.6% of Los Angeles doctors accounted for 30% of all payments).

B. Doctors who do few procedures subsidize doctors who do many procedures. Under the current rating system in use in most states, the general practitioner who delivers a few babies each year pays as much as OB/GYN's who deliver hundreds of babies.

C. Insurance companies divide doctors into too many categories with too few doctors in each. As a result, one large judgment against a doctor in a sparsely populated category can mean a very large premium increase for all doctors in that category. If the number of categories were reduced and the number of doctors in each category increased, insurance premiums would decrease dramatically for doctors in high risk specialties (while rising only slightly for doctors in other specialties).

D. Doctors pay when hospitals should pay. Today, when negligence occurs in a hospital --e.g., in connection with surgery or delivering babies -- the insurer for the doctor doing the surgery or delivering the baby must pay for the negligence. The hospital therefore has little incentive to police doctors who practice there, while the cost of high-risk care is borne by a small number of doctors.

If procedures done in the doctor's office were charged to doctors, while procedures done in the hospital were charged to the hospital, the cost of high-risk care would be spread over a large number of beds, hospitals would have a greater incentive to police doctors, and malpractice insurance premiums for most doctors would fall. See generally Public Citizen's Health Research Group, "Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform," August 27, 1985, and studies therein cited (unanimously concluding that doctor discipline is inadequate).

III. MEDICAL MALPRACTICE INSURERS HAVE RAISED RATES MORE THAN IS ACTUARIALLY JUSTIFIED IN RESPONSE TO "SUGGESTIONS" FROM LLOYDS OF LONDON.

According to the President of the doctor-owned malpractice insurance company in Maryland, "in order to keep [Lloyds] participation on cover we had to agree to some strong suggestions from the reinsurer to beef up the rate charged to the OB's." Statement of John Spinella, President, Medical Mutual Liability Insurance Society of Maryland, before the Governor's Task Force on Medical Malpractice, October 22, 1985.

In addition, requests for rate increases are often based on false assumptions. For example, the Maryland Mutual sought a 29% increase in 1985 based on the assumption that it would earn a 5% annual return on its investments (although it had traditionally earned and was currently earning more than 9%) and that inflation would be in excess of 10% (although inflation was at that time under 10%). If proper assumptions were made, the insurance company would need a .9% reduction in its rates rather than a 29% increase to maintain its current rate of return.

IV. TORT REFORM WILL NOT BRING DOWN MEDICAL MALPRACTICE INSURANCE RATES.

The president of the doctor-owned malpractice insurance company in Maryland recently admitted that "Even if every one of the Task Force's recommendations [on tort reform] were fully implemented, we doubt that there would be any discernible change and fear that the problems may be exacerbated." Letter of John Spinella, President, Medical Mutual Liability Insurance Society of Maryland, before the Governor's Task Force on Medical Malpractice, October 22, 1985. And a recent study for the US Health Care Financing Administration analyzed the effect of caps on awards and other limitations on malpractice suits enacted during the mid-1970's and concluded that these "reforms" did not result in lower insurance premiums. Sloan, State Responses to the Malpractice "Crisis" of the 1970's: An Empirical Assessment, 9 Journal of Health Politics, Policy and Law 629 (Winter 1985).

NATIONAL INSURANCE
CONSUMER ORGANIZATION

HOW TO BRING DOWN MEDICAL MALPRACTICE INSURANCE RATES

1. Require insurance companies to experience-rate doctors. Drivers who have been in several serious auto accidents pay more, and drivers who have never had an accident pay less. Yet doctors found liable for malpractice several times pay the same as doctors who have never been sued. This does not make sense; good doctors, like good drivers should pay less, and doctors involved in malpractice, like drivers involved in accidents, should pay more.

2. Reduce the number of categories of doctors and increase the number of doctors in each category so that risks are spread as widely as practical.

3. Charge malpractice occuring in doctor's offices to doctors and charge malpractice occuring in hospitals to hospitals, both to maximize the incentive of hospitals to police doctors and spread risks more widely.

4. Tighten state rate regulation of malpractice. (See NICO fact sheet, How to Solve the Insurance Crisis -- What States Should Do).

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HOW TO SOLVE THE INSURANCE CRISIS — WHAT CONGRESS SHOULD DO

1. Subject the insurance industry to the anti-trust laws, thus preventing insurers from acting in concert to raise prices. Since 1944, the McCarran-Ferguson Act has allowed insurance companies to fix prices, while price-fixing in other industries is punishable by three years in jail.

2. Create a federal office of insurance to monitor the industry and establish standards for state regulators to follow. Although insurance is a national, $310 billion business, accounting for 12% of our gross national product — more than any other item except food and housing — only the states regulate the insurance industry. Because state insurance commissions are often under-staffed (half the states have no actuaries to analyze rate filings) and because state insurance commissioners typically come from and return to the industry, state regulation has not always protected the public.

3. Repeal the insurance industry's exemption from Federal Trade Commission jurisdiction. In 1979, after the FTC published a study critical of the life insurance industry, Congress prohibited the FTC from ever again studying — let alone prosecuting — any sector of the industry. There is no principled justification for this exemption.

4. Expand the Risk Retention Act, which currently allows manufacturers — but not other businesses, such as day care centers and nurse-midwives — to join together to self-insure or to buy insurance at a lower rate. This would pre-empt state laws prohibiting such group buying. Automobile owners, for example, who must now buy insurance individually, could reduce their premiums by 10% a year by buying in groups.

5. Establish a national insurance industry-funded reinsurance program. Reinsurance is insurance for insurance companies: the insurer pays the reinsurer a premium, and the reinsurer agrees to share the risk with the insurer. Because the reinsurance market is dominated by Lloyds of London, which is not subject to federal regulation, US insurers have no effective recourse when Lloyds raises its rates, as it did in 1985. A US reinsurance program would compete with Lloyds and exert downward pressure on reinsurance rates, which in turn would enable insurers to reduce their rates. Congress established a similar program, which made a profit of $125 million, to reinsure insurers against riot-caused damages in the 1960's.

HOW TO MAKE THE LEGAL SYSTEM MORE EFFICIENT

1. Limit defense lawyers' fees. Since 1956, defense lawyers' fees have risen almost three times as fast as the amount insurance companies pay to injured people, according to the National Association of Independent Insurers. Of the money spent by a corporation in a typical liability case, more money goes to the defense lawyer than to either the plaintiff's lawyer or the plaintiff himself.

2. Establish automatic, severe sanctions for frivolous motions, objections, and defenses. Because defense lawyers charge by the hour, they have an incentive to delay. To "keep their meters running," they may raise defenses, file motions, interpose objections and brief and rebrief the same issue — no matter how untenable their position — even if settling the case quickly would save their clients money. As long as there is no effective sanction for such tactics, defense lawyers will continue to delay — to the detriment of the legal system and often of their own clients.

3. Limit plaintiff's lawyers' contingency fees to one-third. Plaintiff's lawyers have no incentive to delay, since they get paid only if and when they win. And the contingency fee system is invaluable in allowing average people who could never afford to pay a lawyer by the hour their day in court. But if a lawyer will take a case only on a 40% or 50% basis then the case is too speculative and probably should not be brought. The traditional one-third contingency fee has worked well for both attorney and client and should not be exceeded.

4. Prohibit secrecy agreements. Defendants will often settle a case only if the plaintiff agrees never to disclose evidence in the case to any other plaintiff. Such agreements create more unnecessary work for defense lawyers and force plaintiff's lawyers to continually re-invent the wheel.

5. Expand the use of offensive collateral estoppel. Even when courts have already held a product to be defective, each plaintiff injured by that same product must re-prove that the product is defective. Again, this creates unnecessary delay and unnecessary work. It would be much more efficient to allow prior holdings that a product is defective or that a product has caused an injury to be used in other cases.

6. Transfer relatively small cases where the deterrent function of the tort system is less important into alternative, "no-fault" type systems. For example, in auto accident cases, where criminal penalties and the instinct toward self-preservation presumably deter negligent conduct, a well-structured no-fault system may compensate people more efficiently than the tort system without substantially lessening deterrence.

7. Increase the use of voluntary arbitration and mini-trials as alternatives to the tort system.

8. Transfer all inter-defendant disputes -- e.g., between a manufacturer and its insurance companies -- into an alternative dispute resolution system.

9. Establish nationwide and world wide service by mail to the greatest extent possible. With many corporations doing business through subsidiaries in all 50 states and throughout the world, service on a subsidiary should be service on the parent. Today, particularly when Japanese holding companies are defendents, it may take months just to perfect service.

10. As a prerequisite to any changes in the legal system, the insurance industry must agree that it will lower its rates by a specific amount if specific changes are enacted. Otherwise, such changes are futile.

QUESTIONS FOR ROBERT HUNTER

1. At our first hearing on the malpractice insurance crisis, we heard from doctors who, through no fault of their own, had to curtail their practices because they could no longer afford malpractice insurance, and we heard from consumers who had lost access to needed medical services because their doctors had cut back their practices. Also, we've heard of the need for tort reform and no need for such reforms and that insurance companies are the problem. So let me determine at the outset whether you feel that a genuine problem exists--at least in perception if not substantively?

2. Is there any action this committee can take to encourage a more effective disciplinary system for malpractice?

3. Should the tort law of joint and severable liability be addressed in my proposed legislation, and if so, what should be done about it?

4. Mr. Hunter, you have proposed a federal office of insurance to monitor the indsutry and establish standards for state insurance regulators. What sort of standards could this office establish that would help solve the malpractice insurance crisis?

5. Is there any way that these standards could be established without setting up a federal office to monitor the insurance industry?

6. As I understand your testimony, you think the single most important factor in the malpractice insurance crisis is the pricing of insurance depending upon the level of interest rates and opportunities for investment income. Don't the states have adequate authority to regulate these cyclical pricing policies?

7. Mr. Kemp has told us that the Massachusetts State Insurance Commissioner recently disallowed half of a rate increase proposed by the state's joint underwriting authority, a non-profit entity. Mr. Kemp has stated that the reduction was based on a conclusion that the JUA's estimate for reserves needed to pay future claims was too high. Do you feel that private insurance carriers may be over-reserving for malpractice claims and thus charging more than they need to for malpractice insurance?

8. Mr. Belden stated that up to two-thirds of the claims against health care providers insured by St. Paul are closed without indemnity payment. Would it be fair to say that this indicates that a great number of frivolous claims are being filed against the medical profession?

9. Since most companies are now writing claims made policies, is it justified to continue reserves as tax deductions?

10. Since St. Paul's testifies that the interest income on the reserves actually is used toward paying expenses in claims management, and thereby implicitly impacting premiums, is your cyclical theory still justified?

11. In the Maryland Mutual example in your written testimony, a 29% increase in 1985 premiums was based on an assumption with the 5% return on investments and inflation in excess of 10%. I believe inflation rose approximately 3.8% in 1985 and corporate return on investment averaged approximately 10.8%. What adjustments should be made in accounting practices and premium pricing where such assumptions are so obviously unjustified?

12. What are your impressions of the medical malpractice insurance (copy attached) introduced by Senator Gore and discussed at the July 22, 1986, hearing of the Senate Labor and Human Resources Committee?

RESPONSE TO QUESTIONS SUBMITTED TO ROBERT HUNTER BY ORRIN HATCH, CHAIRMAN OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES

1. There is a genuine problem but it is not caused by the law, it is caused by the allocation of costs.

2. Yes, and it is an urgent need. You should at least undertake a study of how to improve physicians discipline, including how to upgrade such discipline to that of the better states -- such as Utah.

3. Not until data showing how joint and several liability impacts costs in medical malapractice are produced by insurers. Even then, innocent victims should not bear the cost but consideration might be given to creation of a fund for fair allocation of joint and several -- perhaps funded by state premium taxes.

4. It should monitor the macro-economic trends of the insurers and work with the states to control the cycle. It could require better accounting systems so that we would not be in a position, as today, where data on the causes of malpractice and the tort system is unavailable. It could require full factoring of investment income into rates, etc.

5. Perhaps through interstate compacts.

6. Yes. But they are mainly incompetent to do so. See GAO, 1979 Report, "Issues and Needed Improvements in the State Regulation of Insurance."

7. Yes.

8. Perhaps, but these are complex cases at times. We support penalties for frivolous suits and frivolous defenses.

9. Yes. But they should be discounted to present value.

10. Yes. The bottom line profit is clearly cyclical.

11. Ratemaking should be internally consistent, which was clearly not the case in Maryland. Adequate professional staff for the department, some federal standards for accounting and ratesetting and a public representative before the commissioner, would assure, I believe, that such inappropriate ratemaking practices would stop.

12. While we have not had an opportunity to carefully analyze the bill, my impressions are as follows:

The sections requiring certain information to be disclosed are excellent. Particularly essential is section 201, which requires insurance companies to report all payments made in medical malpractice cases.

On the other hand, we have serious concerns about the apparently blanket immunity from damages under any law for professional review bodies and their members. In addition, while we applaud the requirement that the information required to be disclosed by the bill be made available to both HHS and state licensing boards, we believe that the information should also be made available to the public.

It may be possible to accomplish the goals of the bill without exempting professional review bodies and their members from important U.S. laws -- such as the antitrust and civil rights laws -- by requiring only insurance companies to report. My understanding is that much of the information required to be reported under sections 202 and 203 is already reported, while virtually none of the information required to be reported under section 201 is.

The **Chairman**. Mr. Kemp, we will turn to you.

Mr. **Kemp**. Thank you, Mr. Chairman.

I am Stewart Kemp, director of the Massachusetts State Insurance Rating Bureau, and I am particularly grateful for the opportunity to testify here today, as I served for 2 years during the 96th Congress as special counsel to the Senate Antitrust Subcommittee.

To save time, I will highlight my prepared remarks and offer the full statement for the record.

The **Chairman**. Thank you.

Mr. **Kemp**. Liability insurance issues are now at the forefront of regulators' concerns up in Massachusetts. Just last week, I completed presiding at a hearing to consider fundamental changes in the rates, classifications and policy forms proposed for commercial general liability insurance. This hearing lasted 8 days, and we heard 21 witnesses to consider this controversial subject.

I would like to touch briefly on two issues: the broad antitrust immunity granted the business of insurance by the McCarran-Ferguson Act, and the Massachusetts response to the problems of availability and affordability in medical malpractice and liability insurance.

Somewhat surprisingly, it is really little more than historical quirk that has led to the antitrust immunity enjoyed by the insurance industry today. In 1868, amidst the first stirrings of insurance regulation in this country, the Supreme Court held that insurance was not commerce, therefore not interstate commerce, and therefore not subject to Federal as opposed to State jurisdiction under the commerce clause.

But in 1944, 75 years later, the Supreme Court definitively reversed itself and held the opposite, that insurance was commerce after all, therefore that the antitrust laws would apply.

This led to great consternation among both the insurance industry and the well-established system of State regulation at that time. They combined forces, essentially, and within 9 months, despite the exigencies of World War II, the McCarran-Ferguson Act was enacted.

It is important to recognize that this contains two elements. The first is a statement of policy that the States rather than the Federal Government should regulate insurance; second—and it is important to recognize, I think, that this is separate—is the antitrust immunity, which is very broad, which applies to the entire business of insurance so long as it is regulated by State law. Only boycotts, coercion and intimidation are excepted.

As a result, the insurance industry stands alone among major American industries in being largely exempt from both Federal regulation and the antitrust laws. Collusive practices such as joint price-setting that would be per se violations of section 1 of the Sherman law are not a violation under the McCarran-Ferguson Act because of the immunity.

The most indepth analysis of this subject was conducted several years ago by the National Commission for the Review of Antitrust Laws and Procedures. While I suggest reading the full chapter of the report dealing with the immunity, I note that the Commission concluded nearly unanimously that the current broad antitrust immunity for the business of insurance granted by the McCarran Act should be repealed and in its place, narrowly drawn legislation should be adopted to affirm the lawfulness of a limited number of essential collective activities under the antitrust laws.

The Commission found that as interpreted by the courts, the exemption has in fact served as a broad grant of immunity for unsupervised collective behavior by insurers and effectively may immunize from the antitrust laws a broad range of anticompetitive activities.

Recent developments in the insurance industry, I would suggest, underscore the soundness of the Commission's recommendation. In the area of liability insurance, we in Massachusetts have been inundated with complaints of cancellation or nonrenewal of business liability insurance. Stories of rate increases of hundreds, even thousands of percent, are commonplace. Some insurers report they have been unable to obtain needed limits of coverage at any price.

These problems have not been limited to a handful of carriers or a few business segments. Rather, they have been widespread throughout the State. At our bureau, we have reviewed more than 100 proposed liability rate increases in the last year alone. Perhaps surprisingly, our actuaries have found most to be unjustified or excessive, and this is giving full credence to the actual loss experience which is reported by the companies. We find that many of the filings lack even the basic loss data, whether frequency or severity, but the entire historical record of losses, and they often lack the actuarial analysis which is necessary to determine whether or not the proposed rates are reasonable.

We find, though, that our impact on the marketplace is limited. In our State, medical malpractice is almost alone among the liability lines in being required to be made available under State law. Other types of liability insurance are at the discretion or the insurer.

We actually have been advised by carriers on occasion that they would simply not sell insurance at the very highest rate within a range of actuarial reasonableness that we have determined through our actuaries is actuarially sound.

We note further that because of exemptions that exist in most if not all States, that some liability insurance is totally exempt from any State regulation. This is the so-called surplus and excess lines market where, if a broker finds that the coverage cannot be placed with an admitted or licensed carrier, that broker is able to place the insurance with a so-called surplus lines carrier, and under our laws and the laws of most if not all States, there is absolutely no requirement that the rates or the forms or any other aspect of the transaction be submitted to the State for review or be subject to any approval by the State.

The **Chairman**. Mr. Kemp, your time is up. We will pay strict attention to the rest of your statement.

Mr. **Kemp**. I will just conclude, Mr. Chairman, by saying that I am very grateful for the opportunity to be here today, and I urge you and the committee to reconsider the McCarran antitrust immunity in light of this recent experience and to take a close look at what is happening in the economics of the marketplace for liability insurance in determining what public policy is appropriate here.

Thank you very much.

The **Chairman**. Thank you.

[The prepared statement of Mr. Kemp follows:]

Statement of Stewart W. Kemp
Before the United States Senate
Commmittee on Labor and Human Resources
July 22, 1986

Mr. Chairman, members of the Committee, I am Stewart W. Kemp, Director and Chief Counsel of the Massachusetts State Insurance Rating Bureau. I am particularly grateful for the opportunity to testify before you today, as I spent the two years of the 96th Congress as Special Counsel to the Senate Judiciary Subcommittee on Antitrust, Monopoly, and Business Rights, concentrating on insurance issues.

Liability insurance issues are now at the forefront of insurance regulators' concerns in Massachusetts, as they are nationwide. Just last week I completed presiding at a hearing to consider fundamental changes in the rates, classifications, and policy forms proposed by the insurance industry for use in commercial general liability insurance. This hearing, during which 21 witnesses testified over eight days, has been the longest public examination of this major proposal conducted by insurance regulators in any state. During the past year the rating bureau that I direct prepared a 119-page actuarial analysis of medical malpractice rates and presented the resulting recommendations in a 23-day rate hearing.

This afternoon I would like to address briefly two distinct but related topics: the broad antitrust immunity granted the business of insurance by the McCarran-Ferguson Act, and the Massachusetts response to the problems of availability and affordability of medical malpractice and liability insurance.

It is little more than a historical quirk that has led to the antitrust immunity enjoyed by the insurance industry today. In 1868, amidst the first stirrings of insurance regulation, the Supreme Court held that insurance was not commerce and therefore not interstate commerce subject to federal rather than state jurisdiction under the commerce clause of the Constitution. (Paul v. Virginia, 75 U.S. (8 Wall) 168.) Years later when the Sherman, Clayton, and Federal Trade Commission Acts were passed, this holding precluded their application to the business of insurance. By the time the Supreme Court reversed its 1868 holding in 1944 in the South-Eastern Underwriters case, holding that insurance was commerce after all, both a pattern of insurance industry practices that were clearly impermissible under the antitrust laws, as well as the system of state insurance regulation, were well developed. (U.S. v. South-Eastern Underwriters Ass'n, 322 U. S. 533.) Since the Supreme Court's about-face threatened the status quo, insurance companies and state regulators combined forces to urge Congress to reverse the Court legislatively. This pressure was successful. Despite the exigencies of World War II, Congress passed and President Roosevelt signed the McCarran-Ferguson Act in March, 1945, only nine months after the Court handed down the South-Eastern Underwriters decision.

It is important to recognize that the McCarran Act contains two separate elements. First, it is a delegation to the states by the federal government of its newly determined power to regulate the insurance business. Second, it is a broad grant of immunity from the antitrust laws, save only for agreements and acts of boycott, coercion, or intimidation. Is this immunity overbroad? Does it produce anti-competitive results? I submit that the answer is yes in both cases.

The insurance industry stands alone among major American industries in being largely exempt from both federal regulation and the antitrust laws. Collusive practices such as joint price-setting that would be per se violations of Section 1 of the Sherman Act if engaged in by firms in other industries are protected when practiced by insurance companies. Yet there is no countervailing constraint arising from oversight by a federal regulatory agency.

The most in-depth recent analysis of the insurance industry's antitrust exemption was undertaken by the National

Commission for the Review of Antitrust Laws and Procedures. Reporting in 1979, the Commission recommended nearly unanimously that the "current broad antitrust immunity for the business of insurance granted by the McCarran-Ferguson Act should be repealed. In its place, narrowly drawn legislation should be adopted to affirm the lawfulness of a limited number of essential collective activities under the antitrust laws."

The Commission's analysis of the McCarran immunity - to which a full chapter (11) of the report was devoted - is telling. The Commission found:

> Both the language of the McCarran-Ferguson Act, and the Act's legislative history, make clear that the purpose of the insurance immunity was to permit state regulatory mechanisms to function without federal intervention, and not to give the industry broad license to operate without antitrust scrutiny. As the Supreme Court recently noted, the purpose of making antitrust immunity dependent on state regulation was to end the "'system of private government'" prevalent in the insurance industry before McCarran-Ferguson, and while agreements among insurers might be permitted, "'public supervision of agreements is essential.'" [St. Paul Fire & Marine Ins. Co. v. Barry, 98 S. Ct. 2923, 2933-34 (1978) (quoting Senator O'Mahoney, floor manager of the McCarran-Ferguson Act).]

The Commission noted that despite these purposes, "as historically interpreted by the courts, the exemption has in fact served as a broad grant of immunity for unsupervised collective behavior by insurers. Courts have refused to require that the state regulation be comprehensive or effective as a condition for permitting immunity to attach." The

Commission concluded: "As presently interpreted, the McCarran-Ferguson Act effectively may immunize from the antitrust laws a broad range of anticompetitive activities which, in fact, serve no federal or state objectives.... Just as importantly, the presence of antitrust immunity has permitted insurers and state regulators to avoid any inquiry into the appropriate limits that should be placed on insurance companies' collective activities."

The Commission concentrated its analysis of the anti-competitive consequences of the McCarran immunity on the impact of rate bureaus. Under the protection of the immunity, competing insurers are able collectively to publish industry rates for future periods based on industry average costs. No differentials need be established based on differences in costs or efficiency among insurers operating in the same market. Observing that regulatory mechanisms in many states discourage independent pricing behavior, the Commission expressed its belief that the cost of the insurance exemption is significant. The Commission found that the existing immunity is "overly broad" and recommended new legislation in its stead that would confirm the lawfulness of enumerated essential collective activities, such as the pooling of statistics concerning past losses.

Recent developments in the insurance industry underscore the soundness of the Commission's recommendation. In the area of liability insurance, we in Massachusetts have been inundated with complaints of cancellation or non-renewal of business liability insurance. Stories of rate increases of hundreds or even thousands of percent are commonplace. Some insureds report that they have been unable to obtain needed limits of coverage at any price.

These problems have not been limited to a handful of carriers or a few business segments. Rather they have been widespread throughout the state. At the Massachusetts State Rating Bureau we have reviewed more than 100 proposed liability rate increases in the last year alone. Perhaps surprisingly, our actuaries have found most to be unjustified or excessive. Many filings lack the basic loss data and analysis necessary to determine whether the proposed rates are actuarially sound. Yet despite these actions, our impact on the marketplace is limited. With the exception of medical malpractice and commercial automobile insurance, carriers are not required by law to sell business or professional liability insurance. Therefore they are not required to accept applicants at the filed rates. On occasion, carriers have advised us that they will not sell insurance at the highest rate our actuaries have determined is actuarially sound, based on the carrier's loss and expense experience, reasonably projected into the future with allowance for investment income.

Even when rates as filed are used, insurers have substantial discretion to modify premiums depending on classification assignments, underwriting discretion, and retrospective rating plans. Under the laws of Massachusetts and most if not all other states, a total exemption from rate and form regulation is available for so-called surplus and excess lines insurance. Under these laws, coverage that cannot be placed with an insurer licensed in the state may be placed by a specially licensed broker with unlicensed foreign or alien insurers. The rates and policy forms used for such insurance are totally exempt from regulatory review or approval. Finally, insurance that is placed directly with a company that does not transact business in the state is also not subject to regulation.

Under the McCarran Act, the activities of insurers involved in providing liability insurance are largely exempt from examination under the antitrust laws. I have not conducted an investigation to determine whether the problems now being experienced in Massachusetts and across the country in the liability lines are the result, in whole or in part, of collusive activity or other actions in restraint of trade that would be unlawful if the antitrust laws applied. Certainly many companies are involved and there is the appearance of concerted action. But I see no reason for the business of insurance to be automatically shielded from any examination on this question. And exposure to the full ambit of the antitrust laws would provide a powerful incentive for insurers to avoid anti-competitive collective activity.

It must be emphasized that repeal of the antitrust immunity does not imply the introduction of federal regulation of insurance. The subsection (2(a)) of the McCarran Act that establishes the primacy of state regulation is both statutorily and analytically separate from the subsection (2(b)) that establishes the antitrust immunity.

The recent experience in the liability lines indicates that repeal of the antitrust immunity is not of itself sufficient to assure economically and actuarially sound pricing. Insurance is nearly unique among goods and services in that its costs are unknown at the time of sale. In addition, costs vary with the purchaser. These two characteristics combine to make the pricing of insurance more difficult than that of most goods and services. In cases where the degree of uncertainty is great or where costs are changing rapidly, the difficulty becomes enormous. Prices rise to reflect this uncertainty; in extreme cases the market mechanism may break down entirely and no price at all is set. (A comprehensive analysis of these issues is contained in a law review article, Insurance and Competition, that I wrote several years ago. I offer a copy for inclusion in the written record of this hearing.)

The Massachusetts experience with medical malpractice insurance is an excellent illustration of the consequences of these forces. Back in 1975, a time of sharply rising malpractice claims, the insurers then writing this line of insurance simply refused to keep writing it on a voluntary basis. The private market broke down; the prerequisite of willing sellers to the functioning of any market was no longer satisfied. In order to deal with the massive availability problem that resulted, the legislature established a joint underwriting association ("JUA) consisting of insurers authorized to write liability insurance. Under the governing statute, this entity must sell malpractice insurance to licensed physicians who pay their premiums. But the Commissioner of Insurance, rather than a private insurance company, sets the rates. The law requires that he do so on an actuarially sound basis. In part because insurers are potentially assessable for deficits incurred by the JUA, each year the JUA submits recommendations for rate changes. For the most recent proceeding, the JUA proposed a rate increase of 138 percent. In contrast, the State Rating Bureau actuary testified that an increase in the range of 3 to 56 percent would be adequate, depending on a range of high and low actuarial assumptions. Two actuaries put forward by physician groups testified that an increase in the 60-70 percent range would be sufficient. After reviewing all the evidence and testimony, the hearing officer implemented an increase of 68%, slightly less than half what the JUA had proposed. He found that the JUA's projections of future losses were excessive.

The long "tail," or lag between date of injury and date of ultimate claim payment, of the malpractice line - like other liability lines - exacerbates the degree of uncertainty in rate-making. We do not now know whether the current rates will turn out to be too high or too low. We do, however, have nearly final data for the early years of the JUA, 1975 through 1978. Despite the fact that the rates established for those years were significantly below those recommended by the JUA, the actual experience - now that the claims have come in - has shown the state-made rates not only to have been adequate, but quite profitable as well.

In conclusion, I would like to express my appreciation for the opportunity to testify here today. I urge you to reconsider the appropriateness of the McCarran antitrust immunity, and I stress the importance of considering the implications of the unique difficulties of pricing the insurance product as you formulate public policy in this area.

Thank you.

The CHAIRMAN. Ms. McKnew, we will finish with you.

Ms. MCKNEW. Thank you, Senator Hatch.

I will try to keep my relevancy down to 5 minutes. I am not a lawyer, I am not a doctor. I do not represent the insurance industry. I have no vested financial interest. I have no money to give. I have no money with which to influence, or purchase tables or fancy charts.

I happen to be the mother of a young man who was paralyzed several years ago in an accident. He is a quadraplegic. And in December of last year, we decided, about six of us, that enough of the doctors, enough of the lawyers, and enough of the insurance industry had been heard from, and nobody had heard from the victims. So we are now calling ourselves Victims United, and before you institute some massive legislative proposals, we thought you might like to hear three very short stories, real life, true life adventures. And perhaps it might help if we shared with you what we thought would be the consequences if any of these so-called tort reforms were instituted.

In 1982, a mother and a father brought their 15-year-old daughter to the hospital for the removal of a slow, very small brain tumor, slow growing. Tests made prior to the operation indicated that once removed the tumor's effect would be minimal, that their daughter would be seizure free, and her ability to earn back her A average in school would be assured. The wonders of technology had permitted the early discovery of the tumor by CAT scan. However, 24 hours postoperation, the doctors discovered the young woman could not remember anything longer than 30 seconds. A followup scan demonstrated that he had operated on the wrong side of the brain, removing healthy functioning tissue.

Despite the healthy appearance of the brain tissue on the left side, the doctor had removed it negligently depending on his interpretation of the scan. The family sued and collected $3 million.

Another woman was pregnant with her second child, unconcerned about any potential problems. Her first delivery had been relatively easy. As she began labor, the obstetrician told her to come into the hospital, which she did, and where she remained in labor, unattended, for 18 hours. She knew something was wrong, but she had no choice but to wait for the doctor to agree with her. He never did.

The baby finally descended, feet first, with the umbilical cord tightly wrapped around her neck. With forceps, muscle and ungentle tugs, that baby was pulled into this world of paralysis and wheelchairs and uncontrollable spasms. The mother sued and received $1.5 million on behalf of her baby.

Mrs. S had been a model, and at the age of 69, she looked terrific. She appeared on the tennis court, the pages of Town & Country, and the charity balls she organized as far younger than her years. But she succumbed to vanity and decided that a facial lift and a tummy tuck would help her look the way she felt.

Despite her age, the surgeon scheduled both operations back-to-back. She came through the first one just fine, and she was removed to the recovery room for routine observation. However, she was not observed either by the recovery room nurse or by the monitors, which had failed to be turned on. She remained without sufficient oxygen for almost 15 minutes, and her brain was starved out of function. She requires 24-hour-a-day care, curled up and comatose. Her husband sued, recovering almost $3 million.

Those are horror stories, but they really happened. And I want you to know what some of these current proposals will do for these people.

The cap proposed on the amount of money a jury can award for pain and suffering is $250,000. Jury members do not award fortunes for the fun of it. The psychological trauma families endure is immeasurable, but it exists.

A face burned beyond recognition, a loss of sexual function, the inability to control bowel and bladder activity, the failure of muscles that permit belly laughs or sneezes or a deep breath of fresh air—they really are worth something.

Second, know that once you put a cap on pain and suffering, on the intangible consequences of a memory erased, or quadraplegia, the deterrence function of the tort system is destroyed.

A guaranteed ceiling for malpracticing physicians offers no incentive for careful treatment. Rather, it offers a safety valve for the very few but nevertheless negligent physicians encouraging their continued participation in a system that rewards their failures by protecting their pockets.

Third, the cap on pain and suffering permits the lesser injured patient a cushion of financial support, denying that same cushion to those who are most severely maimed. Those most in need of personal assistance and financial security, and some form of recompense for the burden they bear are sacrificed for an average of $250,000.

What is ironic is that there are very few of these quarter of a million dollar noneconomic damage awards. A cap will save the industry little and impact not at all on the premium rates charged to physicians. The only budget that will feel this cap will be the victim's—and his balance will remain negative, inversely proportionate to his pain.

The periodic payment requirement, aside from its legal legitimacy, results in a very unjust and harmful consequence. If the estimates made at trial prove less than accurate, the victim's medical bills simply do not get paid. The money awarded for a given year is neither retained for the future nor credited from the past. Unspent portions collect as assets for the insurance company, and expenses in excess of the year's allotment are simply not met.

Further, if the needs for one period exceed the budget, there is no medical assistance program to fall back on. The size of the award precludes the recipient from being eligible for State or Federal medical aid programs. The victim "earned" too much money to warrant public assistance.

The experience of those who have been forced into the periodic payment system indicate that the decisions as to what is and is not medically necessary are controlled by the insurance company. The fights I have now with my insurance carrier, the one whose premiums I pay, are exhaustive. Without the help and intervention of your colleagues here in the Senate, my son would not have been able to go to Yale, or to afford a specially adapted van which he drives, or to fund the help he requires just to get up in the morning.

And finally, on the contingency fee restriction, it is one more swipe at the most vulnerable member of this complicated mess. That contingency fee systems permits the poorest of the poor to seek and retain legal help. It is guaranteed for everyone.

Unlike the defending attorney, who gets paid win or lose, however, the plaintiff's lawyer earns only if he or she wins, and the incentive to take only those cases that warrant the risk minimizes the frivolous suit. Frivolous efforts do exist, but they do not abound as has been alleged. It would only take a short string of losses to force the frivolous suit filer to go bankrupt. And indeed, the need to keep costs down is built into the contingency fee system, while the defending counsel can make motions, delay and postpone almost at will, collecting for his time while blaming the costs on the system.

Finally, before you challenge the worth of the plaintiff's attorney's work, ask us. We would have gotten nothing without them. The fee system works, and it works for those it is intended to serve, and that is us.

I had many other counterproposals, not the least of which is to mention that 99 percent of the focus of these hearings has concerned problems of the insurance industry, but none of the proposals have focused at the insurance industry. It would be presumptuous of me to do so, with Mr. Kemp and Mr. Hunter, and with your permission, I will insert my statement for the record.

The CHAIRMAN. We will certainly permit that, and will put all statements in the record. Thank you for your statement.

[The prepared statement of Ms. McKnew follows:]

STATEMENT OF LOUISE McKNEW

Mr. Chairman, honored members of the Committee:

My name is Louise McKnew, and I am deeply grateful for this opportunity to share my views with you. Know in advance that I am not a doctor or lawyer. I do not represent the insurance industry, or an insurance company, or any other enterprise vested with a financial interest in your decisions. I am simply a consumer, a mother, all too familiar with the victims about whom so much has been said but from whom so little has been heard. The five minutes you offer me are seized with the hope that what I say will help you help us, and those who will tragically follow in our footsteps.

Since 1978 I have done little else but to pursue solutions to the problems my children and I have encountered since my son was paralyzed in an accident. I opened the Washington office of the National Spinal Cord Injury Association, serving as director for two years. With a seed grant from IBM I initiated a national toll free hot-line for victims of neural injuries, now operating out of the famed Baltimore Shock-Trauma Center. I co-founded and served a executive director of the National Research Institute for Neural Injury, now supporting a multi-million dollar research center in San Francisco, and serve now on the board of the Institute, and on the board of the Foundation for Critical Care Medicine. In January I left the Institute to work for Jack Olender and Associates, a well-known plaintiff's law firm here in Washington, and have just finished my first year of law school, on scholarship at the University of Maryland, attending evening classes after work.

Innocent of fault, unwary, and unschooled in the world of trauma, I have become an unwilling but acknowledged expert in the medical, legal, financial and insurance consequences of injury. Over the years I have learned that I am not alone, and that there are thousands of others equally expert, innocent and unheard. We now present ourselves as a newly incorporated non-profit organization - Victims United. We have no economic leverage. There is no money to be made by our efforts, and we have none to offer. We have a difficult time bearing our own financial burdens, and cannot contribute as a PAC, or compete with the multi-million dollar campaign mounted by the insurance industry to persuade you that we are the problem. But we can speak, and it is on behalf of all victims, along with their mothers, sisters, brothers and friends that I welcome your offer to listen.

There are two specific areas of concern I would like to address: current proposals for solving the problem, and a counter proposal. But before I offer you opinions I would like to tell you three short stories, three true to life adventures. Each involved a medical accident which resulted in massive pain, catastrophic and permanent injury and fantasy-level financial costs. Each also resulted in proof that our tort system works, and works for those it was intended to serve: the victims.

In 1982, Mr. and Mrs. L. brought their 15 year old daughter to the hospital for removal of a small, very slow growing brain tumor. Tests made prior to the scheduled operation indicated that once removed, the tumor's effect on the high school cheerleader's future would be minimal. She would be seizure-free, and her ability to earn back her A average in school was assured. The wonders of technology had permitted the early discovery of the tumor by CATscan, and the family shared the neurosurgeon's optimism. Less than 24 hours post-operation the doctors discovered that the young woman could not remember anything longer than 30 seconds, a consequence they had not anticipated. Indeed, a follow-up scan demonstrated that the neurosurgeon had operated on the wrong side of the brain, removing healthy functioning tissue. Later, when the correct surgery was performed, the doctors admitted that they had read the CATscan in reverse, confusing the right and left side pictures. Despite the healthy appearance of the brain tissue on the left side, the doctor removed it, negligently depending on his interpretation of the scan. The family sued, and collected $3 million.

K.M. was pregnant with her second child, unconcerned about any potential problems - her first delivery had been relatively easy. As she began labor, her obstetrician advised she come in to the hospital, which she did. She remained in labor for hours, too many hours, 18 hours, unattended. Her physician was not concerned, despite her growing anxiety that this labor was not following the pattern of her other one. K.M. knew something was wrong, but she had no choice but to wait for the doctor to agree. He never did. When the baby finally descended, she did so feet first, with the umbilical cord tightly wrapped around her tiny neck. With forceps and muscle, and ungentle tugs, the obstetrician pulled the baby into a world of paralysis and wheelchairs and uncontrollable spasms. She has a birth-induced cerebral palsy. Her mother sued on her behalf, and received $1.5 million.

Mrs. S had been a model, and at the age of 69 she looked the role. The wife of a wealthy executive, she appeared on the tennis court, the pages of Town and Country magazine, and the charity balls she organized as far younger than her years. In excellent health, feeling fit, she succumbed to vanity and decided to take advantage of the promise of plastic surgery: a facial lift, and a tummy tuck would help her look the way she felt. Her surgeon/friend assured her not to worry, and scheduled her for both operations at the same time, one right after the other. A little old for such rigors, but then she was so active...She came through the facial lift well, and she was removed to the recovery room a second time, following the tummy tuck, for routine observation. However, she was not observed, either by the recovery room nurse or by the monitors available for hook up. The monitor was not turned on, and the nurse was otherwise occupied. Mrs. S. never recovered past a coma - she remained without sufficient oxygen for almost 15 minutes, her brain starved out of function. She remains under 24 hour a day care, curled up and comatose. Her husband sued, recovering almost $3 million.

CURRENT PROPOSALS: The cap you propose to place on the amount of money a jury can award for pain and suffering is $250,000. First, know that jury members are not dumb. They are not awarding fortunes for the fun of it. The psychological trauma families endure is indeed immeasureable, but it exists. Just as Justice Stewart said he couldn't define obscenity, but could tell it when he saw it, so too juries can identify and appropriately assess the value of pain and suffering, even though they cannot produce an economic table with which to measure it. A face burned beyond recognition, a loss of sexual function, the inability to control bowel and bladder activity, the failure of muscles that permit belly laughs, sneezes and deep breaths of fresh spring air - they really are worth something. Second, know that once you put a cap on pain and suffering, on the intangible consequences of cerebral palsy, a memory erased, or quadreplegia, the deterrence function of the tort system is destroyed. A guaranteed ceiling for malpracticing physicians offers no incentive for careful - full of care - treatment. Rather, it offers a safety valve to the very few but very incompetent physicians, encouraging their continued participation in a system that rewards their failures by protecting their pockets, and punishing only the victim, a second time. Third, the cap on pain and suffering permits the lesser injured patient a cushion of financial support, denying that same cushion to the patients who are most severely maimed. Those most in need of personal assistance, and financial security, and some form of recompense for the burden they bear are sacrificed on the alter of averages. - $250,000. What is ironic is that there are relatively few of these quarter of a million dollar non-economic damages awards, and the money to be saved is negligible. A cap will save the industry little- St. Paul's so admitted - and impact not at all the premium rates charged to physicians. The only budget that will feel this cap will be the victim's - his balance will remain negative, inversely proportionate to his pain.

PERIODIC PAYMENT REQUIREMENT: The periodic payment proposal you have offered will prove devastating. I do not know enough of the law to offer an informed opinion, but the little I do know warrants the question as to whether the ennactment of such a law would constitute a taking, violating a constitutional right of property. The economic award belongs to the victim, rightfully "earned," but the periodic payment restriction would keep it in the hands of the wrongdoer, or his representative, to be doled out as estimated by an economist. The owner is deprived of the right to dispose of the property, to invest it, to earn from it, and to reserve it. Aside from the legal legitimacy, there are very practical results which are unjust, and harmful. If the estimates made at trial prove less than accurate, the victim's medical bills do not get paid. The money awarded for a given year is neither retained for the future nor credited from the past. Unspent portions collect as assets for the doctor or the insurance company, and expenses in excess of the year's allotment are simply not met. There is no money available from past reserves, and no loan to be secured against next year's share. Further, if the needs for one period exceed the budget, there is no medical assistance program to fall back on - the size of the award precludes the recipient from being eligible for state or federal medical aid programs. The victim "earned" too much money to warrant public welfare. The experiences of those who have been forced into the period payment system indicate that the decisions as to what is and is not medically necessary remain in the control of the insurance company. The insurer retains control over what does and does not qualify as critical to the victim's continued care. The fights I have now with my insurance carrier, the one whose premiums I pay, are exhaustive. Without the help and intervention of your colleagues here in the Senate my son would not have been able to go to Yale, or to afford a specially adapted van which he drives, or to fund the help he requires just to get up in the morning. The energy needed to fight the insurance clerks whose premiums are paid by the adversary looms overwhelming. Legislate these new restraints and inhibitions, and you compound the problem. You add interest to the coffers of those at fault, maximizing their gain while minimizing ours, and then permit them to heap insult on injury by demanding justification for expenditures we need to survive.

CONTINGENCY FEE RESTRICTIONS: The proposed curb on the trial attorney who represents the victim is but another swipe at the victim, the most vulnerable member of this complicated mess. The contingency fee system permits the poorest of the poor to seek and retain top of the line legal help. Access to redress through the courts is guaranteed for everyone regardless of resources- the only requisite is a wrong. Unlike the defending attorney, who gets paid win or lose, the plaintiff's lawyer earns only if he or she wins, and the incentive to take only those cases that warrant the risk minimizes the frivilous suit. Frivolous efforts do exist, but they do not abound, as has been alleged- it would take only a short string of losses to force the frivolous filer to go bankrupt. In addition, the need to keep costs down is built into the contingency fee system, while the defending counsel can make motions, delay and postpone almost at will, collecting for his time while blaming the costs on the system. Note also that there is probably not much difference in the incomes of a good defense lawyer and a good plaintiff's lawyer. I know of no studies, but I know a lot of lawyers, on both sides, and they all make an enviable living. Finally, before you challenge the worth of the plaintiff's attorney's work, ask the clients: they would have gotten nothing without him or her. The fee system works, for the victim.

COUNTER-PROPOSALS: Please know that I share your sense of frustration at the insurance costs problem. The great majority of fine physicians are paying skyrocketing premiums for no demonstrable cause, and we all suffer the consequences. There are far too many innocent, caring and careful doctors paying the exorbitant costs of an insurance policy they will never need. There are also too many doctors at the cutting edge of medicine who are being sued simply because they tried, with due care and without negligence. But their frustrations, and yours, must not rush you into action, any action, for relief. Such relief,if it comes, will be short-lived. Indeed, the insurance industry has gone on record predicting that even if you do legislate their proposals for tort reform, there is no guarantee that the results will be lower premiums, or even a slower rise in premiums. Just look at Maryland, where tort reforms began in 1973, rates continued to rise, and more reforms were added on the first of July: periodic payments and a cap on the award for pain and suffering. The malpractice rates rose too, again.

INVESTIGATE THE INSURANCE INDUSTRY: It is curious that the problem on which these hearings are focused, and the issues which the proposed bill addresses, are exclusively within the control of the insurance industry. Yet not one of the solutions offered is directed towards that industry. We seem to have taken this giant at its word, accepted its allegations and accusations as fact, and acquiesced to its outrageous and greedy demands with uncharacteristic submission. You have heard from others far more expert than I on the issue of insurance practices, but I would like to share with you some of our discoveries.

The insurance companies have collected their resources and mounted a very persuasive and costly campaign trying to convince you the victim is the villian. They tell the public that there are too many victims, too many claims, too many trials, too many plaintiff's lawyers making too much money, too many juries giving away too much money. All that may be true, but it's not our fault. First, there are simply more people now than there were in the past. The rise in tort claim filings between 1978 and 1984 reflects no more than the rise in population - tort filings increased by 9%, while the population increased by 8%. Second, the size of jury awards for injuries inflicted reflects the rise in health care costs: had my son sustained a broken neck 20 years ago he probably would have died. Today, medical advances and technological discoveries permit him to expect to live a normal life-span: his costs to do so will exceed $5 million. Third, the incidence of medical malpractice suits filed may be too high, but it is not as high as the actual incidence of malpractice itself - a 1973 HEW study noted that only 1.7% of patients who had demonstrable grounds for alleging malpractice actually did so.

The insurance industry is a runaway bandit, unregulated in all but minimal regards, expert at misleading the public, the doctors and the political leadership into reform measures that will benefit only their own. The exemptions the industry enjoys should be removed - take a hard look at the regulatory impositions they don't share with the country's other industries. Then take a look at the enforcing measures never taken for the industry's refusal to abide by the few obligations that are imposed. Take a look at their use of words, statistics, and data sources. Examine their books, compare their line by line cash flow analyses, critique their use of balance sheets with special note as to where they place "debts" to shareholders, "debts" for reserves for estimated payments, and percentages for earnings on investments far below reasonable expectations. Note further their use of the average for computing jury monetary awards, instead of using the median - one million dollar verdict will skew the average for verdicts way out of proportion, distorting the truly representative picture a median gives. Their use of the word claim is not ours - their claim means a phone call regarding a possible suit, while ours, and yours, means a legally acknowledged action. Their data is gleaned from Jury Verdict Research, a non-scientific reporting service which collects information contained in articles appearing in sampled city newspapers. Scanned across the country, this "data" represents only the "newsworthy" stories about the uncommonly high verdicts. And remember that there are no follow-up stories noting a successful appeal, or that the judge, using his discretion, reduced the jury award because he decided it was unconscionably high.

Ask your colleagues how successful they have been in collecting information from the industry - how responsive the industry has been in responding to questions from individual members of Congress: letter after letter is ignored, or answered with we don't have that information, or we don't keep the information tabulated in that form, or we will have to get back to you later, and then silence. Ask also the GAO what problems they have encountered in collecting reliable, replicable and comprehensible information from the insurance companies. We cannot ask GAO to go after answers, but you can, and with your authority perhaps we'll get some. The insurance companies say they are regulated, that the state insurance commissioners oversee their activities. But go look at the state commissioners' offices - there are small staffs, ill-equipped or numbered to carry out their duties on behalf of the consumer, unable to investigate where they see the need, if they see the need: some commissioners' staffs are insurance company puppets.

My prayer is that you will not permit the insurance industry to continue to hold the doctors, the doctor's patients, or the country hostage to their wishes without at least a struggle. What happened in West Virginia will happen again if you do not assume control: when faced with strong regulatory challenges in West Virginia the industry threatened to pull out altogether, a move too close to black-mail. Our proposal to you is that you investigate the validity of the charges the industry makes, its cost-benefit claims, cash flow charts, line item expenses and investment returns. I don't know what you will find, because our efforts to find out have proved futile. But if you tried, my guess is you would find some interesting material. Victims are not allowed access to the information you need, but with the expert assistance of people like Mr. Hunter and Mr. Kemp, I suspect the "windfall" that victims have been accused of enjoying will be found in the industry's vault.

At the least, please look in all the corners before you carve out ours - we are a small, powerless and silent constituency, but we do exist, and we do contribute. Our access to justice, our chance to recover, and our right to pursue what you assume for your own should not lightly be lost. Thank you.

The CHAIRMAN. To my knowledge, no member of this committee including myself argues that we have not had plenty of actual malpractice actions among physicians and doctors. I think everybody pretty well admits that it is there, and it is a problem. But do you as a group think that adequate strides are being made by professional organizations to resolve these difficulties and to discipline their less competent physicians, surgeons, and other health care providers?

Let us start with you, Mr. Bromberg.

Mr. BROMBERG. Well, I can only speak about the one State I know something about, and that is New Jersey. We certainly have developed a rigorous system there over the last 10 years, of very careful review of physicians' actions. The peer review system and the State medical society have—whitewash does not exist in New Jersey. There is no such thing. The State medical society is vigorous in pursuing people who are out of line.

The CHAIRMAN. Do any of the rest of you have any comments? Mr. Shrager.

Mr. SHRAGER. Well, Mr. Chairman, I think your question is terribly well-taken. An earlier witness, who was the president of the Risk Management Foundation of Harvard Medical Institutions, indicated what is now conventional wisdom, that if you have any kind of look at the facts in terms of the paucity of disciplinary proceedings, he put it this way: The efforts of State medical boards in the area of disciplining bad doctors range from between fairly ineffective to useless. Of the small number of official disciplinary actions taken each year, I would say that the vast majority resulted from behavior such as theft, fraud or moral turpitude, rather than clinical incompetence.

I am sure the organized medical community would like to do more about it. To a certain extent they are hamstrung because most of the States include these peer review mechanisms, disciplinary mechanisms, within the mainstream bureaucracy. A system, if it is going to work, should work in a manner analagous to the way the bar has independent disciplinary machinery in the several States. It fits, of course, as you are aware, Mr. Chairman, under the court system. Much more could be done to permit physicians to be disciplining their colleagues. Of course, they have got to want to do it.

The CHAIRMAN. Mr. Hunter.

Mr. HUNTER. Just one statement, very briefly. I would recommend that the committee get from the Health Research Group, the consumer group that deals with health issues, their analysis of that. You might be very interested to find that Utah has the toughest standard.

The CHAIRMAN. Yes, we do.

Mr. HUNTER. But it falls off very sharply after Utah.

The CHAIRMAN. I see.

Mr. Kemp.

Mr. KEMP. Thank you, Mr. Chairman.

I think a lot more can be done in this area. Our State is acting right now, considering legislation which would greatly reinforce our board of registration in medicine—mandatory reporting of malpractice actions by both courts and insurers; creation of a special investigative and disciplinary unit; inclusion of subpoena power, and the grant of good faith immunity to persons who participate with hospital peer review committees in order to further the discipline where it is needed.

I would make one suggestion for the Federal Government, for you and Congress to consider, which is there has been a problem sometimes of a physician who is disciplined, even losing his license in one State, who simply moves to another. And it would certainly be beneficial to have a national system to deal with that.

Thank you.

The **CHAIRMAN**. Thank you. Conceivably, the insurance industry could play a role, Mr. Belden, in disciplining physicians who commit malpractice itself, it seems to me—if nothing else, instituting an experience rating system in which doctors or other providers who lose malpractice claims pay higher malpractice insurance rates.

What do you think about that particular suggestion, you or Ms. Frans?

Mr. **BELDEN**. Well, we have in the past had to look into the idea of an experience rating plan. We do not have an experience rating plan in other than one State right now.

The idea sounds like a good idea, yet there are a number of practical problems with the experience rating plan. One of the practical problems is that there are very few doctors that have more than one claim—extremely few—and our method of dealing with those doctors if they have more than one claim, if the claims look like something has gone wrong, then our method of dealing with it is an underwriting method of dealing with it, that is, not insuring the doctor. Then the doctor has to find insurance elsewhere in order to continue practicing.

The **CHAIRMAN**. I see.

Mr. **BELDEN**. There is another practical problem with the merit rating plan or the experience rating plan, and that is trying to measure what constitutes a claim. Is a claim a claim as soon as it is reported, even though it may be a claim that is ultimately settled and ultimately found that the doctor is not liable; or is a claim a claim that is paid—because if it is a claim that is reported, we may be wrong in which doctors we surcharge.

If it is a claim that is a paid claim, we generally do not end up paying the claim until many years after the loss has been reported, in which case it is well after the fact, and the doctor may have committed malpractice in that time period.

So there really is not a good practical way of determining what the surcharge should be.

The **CHAIRMAN**. I see.

Ms. Frans.

Ms. **FRANS**. I might just point out one related factor, too. Sometimes we will find in our more technical areas where doctors are doing new, innovative sorts of procedures, first, they may find themselves faced with patients who are in poor condition to begin with, in terms of their health, and second, they are doing these more intricate, complicated procedures that may be new state-of-the-art kinds of procedures.

We do find on occasion that sometimes those kinds of doctors—who may be the best doctors around—get a higher number of claims just because of the nature of the type of practice that they have. And that constitutes a problem related to what Steve discussed.

The CHAIRMAN. Mr. Hunter.

Mr. HUNTER. Well, Mr. Chairman, that is why we have to look at a new way to allocate costs. She is making the point perfectly. The few high-risk specialists like neurosurgeons and people like that end up bearing the entire cost, particularly those that deal with the most modern technologies, end up bearing a higher cost of both successful and unsuccessful suits, because they are dealing with the hardest cases, they are dealing with a higher percentage of bad outcomes, and they are dealing with a very sensitive type of surgery and procedures where a minor mistake can cost a million dollars, compared to a minor mistake for a GP, which probably costs nothing.

And yet, we load on, say, 49 neurosurgeons in Wisconsin the entire cost of that on almost no base, only 49 people. It violates the very principles of insurance. The classification system is too refined.

We need to find ways to bill back, to the hospital some of the cost as an incentive for the hospitals to make sure they do not give privileges to incompetent doctors.

And also we ought to be looking at some of the costs being borne by those who refer to the doctors, to get more of a base of the total health care system—because we have a system in aggregate that is less than 1 percent of the health care costs. It is not an expensive system. If we did not have a medical malpractice system, and somebody came to the Congress and said, "Look, I have a plan that can give you a system to take care of all the people who get hurt, and give you some incentives for better medicine, and I will do it for less than one percent," we would probably take it.

So it is not the total cost of the medical malpractice system that is running amuck; it is the allocation that is the problem.

The CHAIRMAN. Mr. Bromberg, in your opinion, is the pressure on insurance companies to settle frivolous claims rather than to expose the physician's reputation?

Mr. BROMBERG. Well, there is pressure. I think it comes not so much from a desire to protect the physician's reputation as it does from what I described briefly before as the loaded deck, the stacked deck, that a defendant faces in a malpractice case.

So that in my view, even with an airtight case for the defense, there is always a chance of losing. And the damages in malpractice cases are so enormous that if there is any chance of losing, an insurer has tremendous pressure upon him to settle—that, added to the fact that the insurers face a duty of good faith and a duty to settle within policy limits if they reasonably ought to do so. And the courts have been very liberal in interpreting that, so that if they fail to settle and the verdict goes beyond policy limits, they can easily pick up the whole tab even if it is beyond their policy limits.

The CHAIRMAN. Mr. Shrager.

Mr. **Shrager**. Yes, Mr. Chairman. I must say, I ought to move across the Delaware River to New Jersey. I do not recognize that set of fact, sir. The statistics remain constant year after year after year. Seventy percent of the cases that go to court—and that is the bottom-line figure—70 percent end up in verdicts for the defendant.

In terms of the burden of proof being shifted, I must say with all due respect to my colleague, that is a very curious statement. It is well-known by men and women of the trial bar in this country, as I believe elementary wisdom, that the burden of proof in the medical malpractice field is the severest cast upon any plaintiff in the tort system. That, sir, I represent would be the consensus view of most experienced professionals.

However, there is a problem. Many suits are brought that ought not to be brought; they are not carefully thought through. And at the State level, many of us are trying to do better because every time a claim is brought, a frivolous claim, or a frivolous defense, it simply generates needless transactional cost, pleasing no one but the attorneys.

But for the most part, sir, I can assure you that the system overall in terms of correlating proper claims with proper results is working well.

The **Chairman**. I see. Now, Mr. Belden has concluded in his statement that up to two-thirds of his company's malpractice claims are closed without any payment at all. You have indicated 70 percent in Philadelphia, and I suspect it is probably about the same in New Jersey.

Mr. **Bromberg**. Higher.

The **Chairman**. How about in Massachusetts?

Mr. **Kemp**. In Massachusetts, of those that go to verdict, it is about 70 percent, I believe, for the defense. But it is only half of all claims that go.

The **Chairman**. But does that indicate to you that a lot of frivolous claims are being filed today? You make a very good point. As a plaintiff's lawyer you have consistently stood for the right of the poor to be able to have attorneys who can take contingent fees. I have a lot of sympathy for that, as you know.

On the other hand, Mr. Bromberg, as a defense lawyer, you have seen a lot of cases brought that really were not meritorious. And they are much more easily brought today, I guess, as a result of the doctrine of informed consent, collateral source, and all these other rules that you have mentioned that are very difficult. In fact, I think the explosion in medical malpractice occurred in Pennsylvania, for instance, with the doctrine of informed consent. As you know, rightly or wrongly, I think that is the way it started to take off.

Do you think a lot of these claims are frivolous? You have been honest enough, Mr. Shrager, to say that that adds to the cost.

Mr. **Shrager**. There is a twin frustration for those who care and have pride in the system and the quality of practice. One is the fact that some cases are not well screened. There are particular challenges in terms of accessing a good and reputable, expert and honest expert screening. There are cases that should not be brought, and tragically, there are an equivalent number of cases that in fact should be brought that never see the light of day.

I think, however, the enduring value of our system is that if someone supposes that they have a claim, it seems to me the burden we ought to cast would be on excluding those people from a grievance procedure, from a dispute resolution mechanism. It is for that reason that many of us as plaintiffs' attorneys, we think at our best serve a salutory role in screening those cases in our office.

Many attorneys do the same. We as professionals need, admittedly, to do a better job in more rigorously challenging these cases.

The **Chairman**. That is great. I want to also tell you that the Plaintiffs' Bar makes a good point—and I have mentioned this in my earlier remarks—about the advantages of the contingent fee arrangement, to provide an opportunity for low-income or indigent patients a chance to get their day in court.

But the way the Plaintiffs' Bar often publicizes the contingency fee system, it seems to be excessive or even abusive. I think the Supreme Court in allowing open advertising has really done the Bar a tremendous disservice—ads in telephone books and in the news media, encouraging people to sue at the drop of a hat, over anything, or if they are unhappy with the results of surgery or any other medical practice or procedure.

Our staff learned not so long ago in a visit to a hospital in a low-income area of a large Midwestern city that informants on the hospital staff sometimes advised lawyers of cases in which a less than perfect medical result was achieved. We were told that the lawyers then could solicit these clients, or would solicit these clients, who are usually poor, usually unsophisticated, usually unknowing and unknowledgeable about the difference between malpractice and undetainable medical results.

So let me just pose this question. Do you think I am making a fairly decent argument that the Plaintiffs' Bar goes too far in advertising and soliciting through advertising malpractice lawsuits? And if so, what can we do about it?

Mr. **Shrager**. Many of us supposed that advertising was not necessary or even seemly. The U.S. Supreme Court resolved the issue for us, rightly or wrongly, in the case of Bates and O'Stein, when it declared advertising to be a form of constitutionally protected so-called commercial speech. That was the decision of the Supreme Court, and it became the law of the land, as certain attorneys felt the need to advertise and some, as your question has suggested and comments have suggested very generously.

The problem is that those who have felt the need to advertise considerably may have done so in certain instances—and I do not suggest how many—because otherwise they felt at a disadvantage in competing.

I do not know what you can do about advertising except to impose standards of responsibility on all professionals, and I think that comes at the State level.

I think bar associations around the country, Mr. Chairman, are sensitive to this issue; I think they are reacting to the issue. But having said that, would you permit me also to say that it has been my experience in dealing with the organized trial bar and getting around the country and knowing distinguished men and women from your State, that by and large, I have always supposed that those who do that, though they get big headlines, are really the occasional professionals, and I have learned to have a sense of pride overall in the caliber, character and ethics of my colleagues in the profession.

The Chairman. I am going to submit a whole raft of questions to all of you. There are many, many questions this committee has. This particular panel is an extremely important panel. It is balanced; it has a lot of differing points of view, and you have been very helpful to me as chairman of the committee. I have a lot more questions, but I do not want to take my colleague's time, having delayed him and delayed the hearing.

Let me just ask one other question, though. Mr. Hunter said in his statement that the primary cause of the malpractice insurance crisis has been cyclical—as I understand your statement—has a cyclical nature as a result of the insurance industry's pricing policies. Did I misstate that, or is that fair?

Mr. Hunter. That is about right.

The Chairman. What is your response, Mr. Belden? I have got to go to another meeting, and I would like to turn the time over to Senator Kennedy to finish his questions and any other Member who comes in, so that we can complete this day's testimony, because this is very important. We do not know quite what to do in this area. And Ms. McKnew, we have much sympathy for your position and for the position of victims, because we do not know how you balance, for instance, the problems that you have mentioned, which are serious problems, with doctors who are now leaving their professions wholesale because they just cannot afford to pay the premiums and stay in their particular specialties of practice. So we are concerned about that.

But let me first ask Mr. Belden about the cyclical nature of the industry, and then I am going to turn to Senator Kennedy.

Mr. Belden. OK. I want to start by repeating my original statement that losses have increased tremendously actually over the last 50 years, although I only showed you the trend over the last 9 years.

The Chairman. Could you pull your mike up just a bit, please?

Mr. Belden. I am sorry. I showed you a chart of medical malpractice losses, the pure premiums, I will call it, over the last 9 years, and that is representative of what has been happening over the last 50 years. Medical malpractice losses have been increasing tremendously over time. This has been a trend over the last 9 years of over 20 percent per year, and the trend has not been as large, but it has been very large in the years before that.

So I am saying that the medical malpractice crisis per se is driven by the underlying losses, by the fact that the doctors' premiums are becoming unaffordable because they are getting so high.

The Chairman. One of the problems we have in the insurance industry, as I see it, Mr. Kemp has told us that his insurance commissioner in Massachusetts disallowed about half of the proposed malpractice insurance rate increases, because of excessive reserve estimates that were established for the Massachusetts Joint Underwriting Authority by St. Paul.

One of the questions that just has to be asked is how can we be sure that St. Paul is not overreserving and thus charging excessive prices in the areas where it markets malpractice insurance. You see, this is going to be an awfully big question: Is the insurance industry at fault here? Does it have some role to play?

Ms. Frans.

Ms. **Frans**. Could I just make one point that I think is a little bit unique to the medical malpractice area, and that is the point that I made earlier, which is that about 55 percent of the market in the medical malpractive field is dominated by the physician-owned or medical society-sponsored carriers. And what we have found is that these doctor-owned companies have experienced the same sorts of trends that we have seen, and yet those are companies that are owned by physicians themselves, but have experienced the same sorts of problems.

In terms of loss-rèserving, I think we find that generally the experience has been, if there has been any problem, in underreserving in the whole insurance field. Just in the last year, about 40 companies have been declared insolvent.

So I think the actual trend has been more in that direction than in overreserving. Certainly, with a commercial carrier which is a profitable enterprise, the incentive is not to overreserve, because that is ultimately reflected in your profits, which would not please your shareholders.

The **Chairman**. I think we had better turn to you, Mr. Kemp, for any comments you might have.

Mr. **Kemp**. Thank you, Mr. Chairman.

We found in Massachusetts where unlike most States, the insurance commissioner fixes the medical malpractice rates. that the rates proposed by the insurance industry have been substantially in excess of those that, according to other actuaries, are needed.

Most recently in Massachusetts, our Joint Underwriting Association, for which the St. Paul acts as the servicing carrier, proposed a 138-percent increase based on their projections of future losses and their reserves and payments on claims to date.

The actuaries of the State rating bureau testified that an increase of up to no more than 50 percent would be fully sufficient to generate actuarially sound rates, and two other actuaries who were retained by other participants in the hearings, physician groups, testified that increases in the range of 60 or 70 percent were fully adequate on an actuarial basis.

All the actuaries had impeccable credentials and were very knowledgeable about the field, and importantly, all worked from the very same data, both the payments for losses and the reserves for outstanding claims which had been reported, but not yet paid.

The Commissioner held that an increase less than half what had been proposed by the JUA was fully adequate, and this has now been accepted, and no appeal has been lodged to the courts, and it is a final rate.

The **Chairman**. That is interesting.

Mr. **Hunter**. If I could just make one comment. The cycle is very clear in medical malpractice, as it has been in other lines of insurance. Ten years ago, when I appeared before Senator Kennedy and talked about the cyclical problems and the overpricing of medical malpractice during the last crisis as a result of the cycle, in 1976, the rate of return on net worth ended up being 45 percent for all the medical malpractice insurers combined, and then 54 percent in

1977. And then they started to cut the premiums, because new capital comes in, obviously, at those levels, and by 1982, they had cut the premiums by about 30 percent, and the profits had fallen to about zero. And now they are on their way back up. St. Paul's profit is skyrocketing right now because of the price increases.

But if you look at the current level of premium in the country compared to 1976, the increase is 3 percent over inflation per year. It is not an explosion. And it has exploded in recent times, but only because they fell so much in premium, and now they are catching back up.

The cycle is very clear.

The CHAIRMAN. Well, thank you.

I am going to turn the remainder of the time over to Senator Kennedy, who also shares my great interest in this subject. It is a very, very difficult area, very difficult to resolve, and I am not sure it is the appropriate area for government to resolve, but I think it is going to come to that, one way or the other.

Let me just turn the remainder of the time over to Senator Kennedy, and I will submit other questions to each of you.

Thank you so much.

Senator KENNEDY. Thank you, Mr. Chairman, and while you are still here, I want to express appreciation for having these witnesses testify and make a record which will be available to our colleagues. I want to apologize to all of you for missing your testimony, but I assure you that we will have the opportunity to examine it and review it. It it not a new issue, as Mr. Hunter pointed out, and it is an issue of enormous importance, and a great deal of misinformation.

I welcome the fact that we had an opportunity today to listen to some of those forgotten individuals that are affected or impacted by this debate and discussion, and that is the victims. I know Ms. McKnew and others have spoken, and it is extremely important when we are considering the various interests that we give priority and attention to the victims in our society.

Mr. Hunter, it has been proposed for years that the McCarran-Ferguson exemption from antitrust liability for the insurance be repealed, and yet the Department of Justice has reported that there is no evidence of collusion in the present liability insurance crisis, but there is a lot of collusion in other aspects. For example, suppose you try to obtain an insurance policy in Daytona and get turned down, and then go on out to San Jose, CA. In San Jose, you find out that the insurance companies got all the information from Florida and it arrives out there before an airplane could get across the country. You are aware that the insurance companies do a very effective job on that, and in many instances, at a very serious disadvantage to the consumer.

How does the Justice Department finding bear on your views on the McCarran-Ferguson exemption?

Mr. HUNTER. Well, first of all, I challenge their findings, since they did not study. I think all they studied was their own philosophy and concluded that anything insurance companies do is all right.

They did no analysis. Compare that to the Ford Justice Department—and I served in the Ford administration—which concluded that the antitrust exemption was too much for the industry, they did not need it; and the heroic leap from saying you might need some joint data collection to saying you should be allowed to fix prices is just not justified.

Then, under President Carter, of course, the Commission on Antitrust Laws and Procedures reached the same conclusion as the Republican Justice Department earlier had reached, that the exemption was way too broad, should be repealed and replaced with some much more narrow allowances to collect data and do some other things that are necessary.

And on the other side, Chairman Rodino has been holding hearings for some time now, a couple of years, on the McCarran-Ferguson Act, and Griffin Bell and many others have testified that the exemption is unnecessary.

The problem is, we have allowed an industry to come together to set prices. This is the third-largest industry in America after food and housing, the third leading purchase that Americans make—12 percent of disposable income goes into insurance premiums; it moved ahead of Federal taxes in this last rate jump, into third place. And yet, the Federal Government has exempted insurance from the antitrust laws, has no office that knows anything about it and to study it; has even said to the FTC, "You are not allowed to even study insurance," in 1981, in the so-called FTC Improvements Act.

The Federal Government has total blinders on in this industry, and we can see now what can happen if we do not have some control over this industry. We are going through the fall-out of that.

And they are allowed to sit down in New York, and they do, and they agree on prices. I was just in a State, working for the Governor a little bit on this problem, and we found that all the malpractice carriers in the State were charging exactly the same bureau rate. There was no variance. They were charging the rate that was agreed to in New York—and it's perfectly legal. But if two corner drugstore people did it, they would be in jail if they agreed to fix prices on their——

Senator KENNEDY. What is the alleged public interest in permitting them to do so? We gave antitrust exemption, for example, to the truckers years ago, during World War II, so that we would be able to keep goods going. It took a long time to get that back and to eliminate the antitrust exemption, which we did in 1979.

Mr. HUNTER. I would suggest that Sandy Kemp is better at that, but I would say this about the alleged public interest of the exemption. First of all, you have to look at the history of the McCarran-Ferguson Act. It was passed without hearings. President Roosevelt was against any extension beyond a 2-year moratorium. Both Houses enacted a 2-year moratorium, and then in conference, somehow, it got changed into a permanent moratorium. There has never been a real hearing on it in the history of this Government. It is a failed law. The State regulatory system has failed. The very cycle that you see here in this chart before me is proof of the failure, because every State has a law that says rates shall not be excessive or inadequate, and yet the cycle itself shows how we go through periods of excessive prices and then periods of inadequate prices.

It is very important that this Congress take a look at that, because sitting in the marketplace is this rate which, when they get into trouble, they go back to, just like sort of a home-base in a game of ringalevio, or something. And it is very important to the crisis that they have this periodic, recartelization capacity that is legal, unlike any other business. In my estimation, there is no justification. But Mr. Kemp is really better-suited to talk about it.

Mr. KEMP. Thank you, Senator, and thank you, Mr. Hunter.

I think that the antitrust immunity for insurance has never been well-thought-out. As I mentioned before, it really is the result of an historical accident, a 19th century holding that insurance was not commerce. When the Supreme Court changed its mind in 1944, the McCarran Act, which accomplished legislatively the exemption, which before had been a matter of constitutional law, simply was pushed through during World War II, with very little consideration.

The most thorough recent examination is the National Antitrust Law Commission that reported in 1979. It concluded that the current broad immunity effectively immunized——

Senator KENNEDY. Who did that study? Was that done in the Justice Department?

Mr. KEMP. I believe it was a commission appointed by President Carter, which included——

Senator KENNEDY. Continue—did they outline a series of other areas of potential antitrust action, too?

Mr. KEMP. Yes, they did.

Senator KENNEDY. I requested that with Jack Javits years ago. That is interesting. Go ahead, please.

Mr. KEMP. And the commission concluded—and I think it was very well-founded—that the current broad insurance immunity effectively protects a host of potentially anticompetitive collective collusive activity which in another industry simply would be automatically a violation of especially section 1 of the Sherman law.

The commission recommended that only a specifically— targeted, narrow exception for essential collective activities, such as the collection of loss data, be permitted. I would suggest that the recent problems with liability insurance underscore the soundness of the commission's recommendation.

Many liability insurance rates around the country are bureau rates which are promulgated industry-wide, based on pooled experience. In addition, even the expenses of doing business—not just the losses, but the insurers' expenses—are pooled, so we lose the essential benefit of independent pricing based on differing degrees of efficiency by different firms in the market.

Perhaps more significantly, in the liability area, we have a system that chills independent pricing and which stimulates what might be described as a "herd" instinct, with everybody running, in this case, straight upwards as far as race.

Senator KENNEDY. Why is that? Explain that to me again. Why is that the effect of this particular provision? What will it do in terms of the larger group rather than treating individuals in terms of their particular record?

Mr. KEMP. Well, the reason, I believe, is because all the industry data are pooled together, and then the actuaries at one central rating bureau compute a rate based on the pooled data, and this is published as just one rate. In some States, there are procedures for a deviation, but I would suggest that the existence of one central industry rate tends to chill that kind of independent pricing.

Senator KENNEDY. Mr. Hunter.

Mr. HUNTER. And Senator, we vary between periods where the industry gets overcompetitive because of their lust for the cash flow, particularly at high interest rates times—they love medical malpractice during high interest rate times—and then we swing into an era of total fear and that is why I call the cyclical pattern, a manic-depressive pattern. At certain times, they are lusting for business and cutting each other's throats, what was called cash flow underwriting, and then later, they come in and refuse to compete, and come back to the bureau rate—which is allowed by the law.

And one gentleman you might want to talk to, I would recommend to the committee, is Congressman Pepper who was then Senator Pepper, who got up on the floor of the Senate and said someday we are going to rue the day that we pass this McCarran-Ferguson Act.

Mr. BELDEN. Senator, I believe when the gentlemen are talking about the rate-setting in concert and the fact that most insurers follow those rates, they are not really referring to medical malpractice insurance, because in medical malpractice insurance, we are the largest writer, St. Paul company; we write 20 percent of the business, and we write at our own rates. Most of our competitors are competitors that have a large portion of the market in individual States, and they are owned by the providers themselves. These are physicians, or the hospitals, and they set their own rates. Very few companies follow the ISO rates, the bureau rates, for medical malpractice.

So when we talk about the exemptions under McCarran—Ferguson, they are not really applying to medical malpractice. They would not make much difference.

Mr. HUNTER. I have to strongly disagree. I am working in a State in the southeast where all three companies are charging the bureau rate, and they are the only three options.

Senator KENNEDY. Yes, do you wish to make a brief comment, Mr. Kemp?

Mr. KEMP. Yes, Senator, thank you. I was referring specifically in the Massachusetts context to business liability insurance, products liability, commercial general liability, and the like. In our State, the medical malpractice rate for most doctors is set by the State. This happened because the private market broke down altogether. We could not have any competition because no company, including the St. Paul, offered to write the coverage.

Mr. BELDEN. At that rate.

Mr. KEMP. I would suggest that our experience as a regulator in Massachusetts recently suggests the concern about the effect of the broad umbrella that the McCarran immunity provides. Even though our laws are set up to allow deviations, to allow insurers to compete on the basis of price, we are finding quite the contrary. We find that most of our rate filings are proposed rates by insurance companies substantially in excess of actuarial indications.

And we are willing to accept the loss data; we accept reasonable trends; we recognize reductions in interest rates. But even with all this, our actuaries find that the substantial majority of the liability filings that we get propose rates that are simply beyond the maximum of the actuarially reasonable range.

Thank you.

Senator KENNEDY. Mr. Kemp, did you listen to Senator Gore's proposal? What is your reaction to his proposal?

Mr. KEMP. I did hear it. I have not had the opportunity to——

Senator KENNEDY. We might make it available to the panel, if you could take a look at it. I would like to ask the majority staff if they would be kind enough to give a copy of Senator Gore's proposal to the witnesses. Please take a look at it and give us your reactions to it.

Mr. KEMP. Certainly.

Senator KENNEDY. On the question of payments to malpractice victims, one of the proposals has been that they be made periodically rather than in a lump sum. What are you views on the effect of this proposed reform on a victim's ability to get needed health care?

Ms. MCKNEW. I think it is a disaster. I think it saves the insurance company a great deal of money. It may indeed force a great many of the victims into medical assistance programs, for which they will not be held eligible.

And I do not know enough about the law yet. I just finished my first year in law school, so I am learning——

Senator KENNEDY. That is the tough one. They are all tough, but that one still stands out in my mind. Pierson versus Post.

Ms. MCKNEW. I am hoping to put that in the past very rapidly.

But I question the constitutionality as to whether or not it is a taking in terms of property. That is property that has been honestly earned, and the individual has no control over it. But it precludes people from taking advantage of medical opportunities, and it prevents them from meeting their expenses as they come up. Most of the individuals I know who have been put on a periodic payment schedule have suffered harm; it has not been a benefit.

Senator KENNEDY. I do not know whether any of the others want to comment on these matters. I will have a chance to review the testimony.

Mr. SHRAGER. I would like to mention one thing, Senator Kennedy, with respect to periodic payments, the voluntary use of which has been taken advantage of. The mandatory use of it violates what I think Judge Learned Hand called the 11th amendment, which was, "Thou shalt not ration justice."

"Periodic payments" are really code words for "cut-rate payments." Periodic payments are great if those who propose them would agree to include cost-of-living increases, increases in the costs of medical care that we know historically have been over 10 percent, and not too many years ago were 15 percent, and you are very, very well aware as a leader on that subject, Senator, that it would take care of contingencies in the future. The problem is, who will bear the risk of the uncertain future. That is what the periodic payment issue is all about.

It is right in the mainstream of anticonsumer proposals, sir.

Mr. **Bromberg**. Senator, if I may, that is contrary to my experience in that I find that at least three-quarters of the cases that are settled are cases in which the plaintiffs ask for periodic payments. The last thing in the world they want is a lump sum. They prefer periodic payments because it guards against squandering the money, for one thing, which is not a rare occurrence, and it also assures money in the future—and sometimes you can get more money that way.

Senator **Kennedy**. I would hope that option would be available to people if they want to choose that way. Clearly, I think we should leave it up to the individual. I am sure there are probably individuals who prefer to have it that way.

Ms. **Frans**. Senator Kennedy, our perspective at the St. Paul Co. is that they would be an option. We do not necessarily think that mandatory structured settlements, in every case, are necessarily appropriate, either for the injured party or for the insurance perspective.

One comment I might make, not representing the St. Paul, but from my practice of law in a defense firm. There were occasionally cases where there were a number of defendants who did not have much insurance coverage available, and, there was a severely injured minor. If those coverages were combined to purchase a structured settlement for the future, you might be able to obtain a better settlement than simply paying out the funds initially.

Senator **Kennedy**. Thank you.

I want to again thank all of you and express my appreciation to the chairman and the staff. This has been a very useful and helpful panel.

I am afraid we are going to be hearing from you again. These issues are not going to go away. Ten years ago, we tried to start in and see where we were going, and then it appeared that the States were going to move ahead. Now we have this issue back here in the Congress, and we will have to wrestle with it one way or the other. But these comments and observations have been very helpful. I want to thank all of you very much.

[Additional material submitted for the record follows:]

STATEMENT OF MERWYN BAGAN, M.D.

Mr. Chairman and members of the subcommittee, thank you for the opportunity to appear here today to discuss the perennial and immensely serious problem of Medical Professional Liability.

I am Merwyn Bagan, M.D., a practicing neurosurgeon from Concord, New Hampshire. I speak for the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, which represent more than 2,900 neurosurgeons in the United States.

The problem of professional liability has existed in crisis proportion for a decade. The differences between 1976 and 1986 are that there are more suits, higher awards, in some cases premium increases of over 300%, and that the pervasive nature of the problem now includes community hospitals, child health clinics, engineers, and indeed lawyers. Another difference is best illustrated by my presence at these hearings today and by the several reform bills now pending before the House of Representatives and the Senate. Such was not the case in 1976.

Before I discuss costs and remedies, let me acknowledge certain absolutes.

1. There are incompetent physicians who should be disciplined.

2. There are legitimate negligence claims for which just compensation should be awarded.

3. Medicine is an imperfect science. To quote Sir William Osler, (the practice of medicine is) "The practice of an art

which consists largely in balancing probabilities... It is a science of uncertainty and an art of probability... Absolute diagnoses are unsafe and made at the expense of the conscience."

4. There are attorneys who will file a case without merit, and as a result the number of frivolous cases has risen dramatically.

5. There is in America, a litigious mentality regarding professional or product liability. This attitude demands a risk-free society.

There are no easy answers to this problem, e.g., the recently published GAO report- Medical Malpractice: No Agreement on the Problems or Solutions.

Mr. Chairman, in the last 10 years 50 states have enacted some degree of tort reform. The resulting impact on the "crisis" has been mixed at best. It is our opinion that it is now time to find a Federal remedy that builds on the various state statutes.

The cost of medical professional liability has been estimated to be in excess of 12 billion dollars a year. A neurosurgeon in New York State may pay more than $100,000 for insurance in 1986. A recent study put the cost of defensive medicine at 30% of the Federal Government's health care outlays. The impact on access to care is very difficult to assess in economic terms. The changing patterns of delivering health care in certain specialties, such as Obs/Gyn and Neurosurgery, are a serious problem. For example, in 1985 the 204 practicing neurosurgeons in New York State were surveyed with 94 respondents providing the following information:

- 87% of those responding are Board Certified by the American Board of Neurological Surgery.
- 100% spent from 5-8 years after medical school obtaining specialized postgraduate training enabling them to deal effectively with surgical diseases of the nervous system.
- the average age at commencement of the practice of neurological surgery is 32.3 years of age.
- the average age of a practicing neurosurgeon in New York State is 50.6 years.
- 31% of those responding plan to retire earlier than expected
- 25.2% of those responding are seriously considering moving out of New York State.
- 53.6% plan to limit their exposure to neurosurgical problems because of the increased litigious nature of our society.
- 68% plan to be more selective in what they do.
- 12.7% already limit their practice to a small segment of neurosurgical conditions.
- 172 suits are presently currently active against the 94 respondents.
- 65 lawsuits were initiated against 44% of the 94 respondents in the past year alone.
- 75 lawsuits brought against the respondents over the years have been dropped without payment before, during, or as a result of a trial.
- 74% consider that the problems relating to medical liability constitute their most serious concern.

- one respondent has had his personal assets attached as a result of a lawsuit.

Included as a part of my statement is a New Hampshire physicians survey done in November, 1984. We think this is important data because it is from a rural and urban state. About one-third (489) of the total number of physicians in the state responded. There were some individuals whose medical liability premium as a percentage of gross or net income exceeded 60%. The following physicians' comments are most notable:

1. From an Emergency Room physician: "Would not resume obstetrics if ever returned to family practice. Approximately 30% of x-rays and laboratory I would consider unnecessary in the strict medical sense, but are done because of potential medical liability or because the patient will be a litigant in some other way."
2. From an Internist: "I gave up my ER duties (2-3 times a month) because of the increase in liability premiums in that area of medicine. Additionally, I would also make the observation that I order many more tests and request many more consultations than my judgment would indicate are truly necessary in order to rule out diagnoses of a very low order of probability."
3. From an Otolaryngologist: "For the first time in my medical practice I must ask the insurance status of ER patients and accident victims because all of my malpractice communication has hinged on uninsured accident or trauma victims seeking sources of financial gain. Although I still

treat these people, the number of x-rays, CT scans, and laboratory tests have increased by a significant amount, as have additional medical consultations and clearances for anesthesia and surgery. My elective patient practices including pre-operative evaluations, laboratory studies, and patient counseling have not changed, however, surgical fees have increased to cover the added cost of malpractice insurance. My use of medical consultants for cardiac, pulmonary and genitourinary systems clearance has increased dramatically for those patients of which I was not 100% sure that a problem did not exist. These consultants have been requested out of the need to protect myself from 'failure to diagnose liability suits'"

4. From a General and Vascular Surgeon: "Presently considering restricting my practice to purely general surgery. Also considering relocating to an area where survival as general surgeon with vascular and trauma is more likely. My practice and consequent medical care for a rural community is in severe jeopardy."

Now I would like to discuss the issues of the cost and remedies.

Organized Neurosurgery proposes that any Federal solution must incorporate the following in order to assure substantial reform and cost savings:

1. Structured Settlements: We endorse the California recommendation to the American Medical Association that any settlement over $50,000 must be structured.

2. Collateral Source Rule: We recommend the definition included in the Moore/Gephardt bill, H.R. 3084. It reads "collateral benefits means all benefits received or entitled to be received by an injured individual under state or federal laws or any health or accident insurance, wage or salary continuation plan, or disability income insurance."

3. Non-Economic Loss: We agree with the decision of the U.S. Supreme Court not to hear an appeal of the California limitation which states "that in no action for injury against a health care provider, based on professional negligence, shall the amount of damages for non-economic losses exceed $250,000."

4. Contingency Fees: We agree with the formula contained in the Inouye bill, S. 175:

    1. one-third of the amount of an award of less than $100,000;
    2. one-quarter of the amount of an award between $100,000 and $200,000;
    3. 20 per centum of the amount of an award between $200,000 and $300,000; or
    4. 15 per centum of the amount of an award in excess of $300,000.

5. Medical Conduct: We agree there must be provisions for quality assurance/risk management. The appropriate model should be a two-tier system. The first tier is the local or hospital level. The second tier is the state level. Much of the mechanism is already in place.

At the local or hospital level there would be two programs. These programs already exist in many states.

The first relates to the impaired/disabled physician. It addresses the emotional, alcohol, and drug abuse problems which impair or disable the physician. Under state law there usually is immunity for the reporting person; otherwise, the program will not work. The afflicted physician is confronted and a treatment program developed. The course of therapy is monitored to assure compliance and effectiveness of treatment. If the impaired physician refuses to participate or if the physician stops treatment, then the state licensing body is notified.

The second program at the local or hospital level relates to quality assurance. Under Medicare and through the Joint Commission for Accreditation of Hospitals (JCAH), quality assurance indicators have been developed by hospital medical and surgical departments. A technician reviews the charts and notes deviations. These cases are reviewed by the chief of service and presented at departmental meetings. The missing element in the system is a flow chart so that trends can be noted. Without the flow chart for review, the chief of service and department members cannot remember from one meeting to the next that a problem is developing or has developed. Once the problem is identified, then the department and hospital executive committee can modify or restrict physician privileges or require additional training. Whenever there is a modification or restriction of privileges, there should be a mandatory report to the state licensing board. The state licensing board would then notify other hospitals at which the physician has privileges. Since there are many physicians who practice in contiguous states, the state licensing board also should notify other states about a modification or restriction of privileges as well as a loss of license.

In order for the system to finction properly at the hospital level, legislation is needed relating to anti-trust or restraint of trade actions. It is the threat of legal suit that in many instances prevents proper action. H.R. 4390, the Health Care Quality Improvement Act introduced by Representative Wyden, addresses this issue. Other immunity laws are necessary so that insurers can relay appropriate information to a hospital executive committee.

At the state level, or second tier, programs might be based on the models of the California Board of Quality Assurance and the Florida Department of Professional Regulation. Most states are financially strapped. Another problem is that in many states physician license fees are adequate but most of the money goes to the general fund and not to the state licensing board. Modest Federal grants to the states, for two or three years, would strengthen Boards of Registration in Medicine. Investigative personnel could be hired. The State Attorney General could designate assigned counsel. We believe it is possible to develop effective risk management/quality assurance programs. It is possible to have effective disciplinary boards. Only thought and money are needed. Both H.R. 2659 introduced by Representative Mrazek and S. 1804 introduced by Senator Hatch contain grant mechanism language.

6. Incentives: The overall adoption, by the states, of this program of tort and administrative reforms should be related to the entitlement programs. We endorse the legislative concept of incentives to the states as a means of accomplishing these reforms.

These reforms would assure that a larger percentage of awards would go to the injured party (plaintiff).

The use of defensive medicine would be reduced. This would represent savings in the billions to the Federal Health Care System.

These reforms could dramatically reduce the cost of insurance premiums to physicians. The AMA, using the actuarial firm of Milliman & Robertson, Inc., estimates that as much as $800 million could be saved if the bill they favor, S. 1804, were enacted into law.

These reforms could reverse an alarming trend among physicians who will not perform certain "high risk" procedures.

Biomedical researchers at our great teaching institutions are withdrawing from their work at the frontiers of knowledge in medicine because of the liability risk. Hopefully, reform would reverse this dreadful trend.

Mr. Chairman, in 1976 there was a professional liability emergency. The patient was treated with a Band-Aid -- an attempt at tort reform and the adoption of continuing medical education requirements. For 10 years the patient has struggled and returns once again in a dire emergency. Draconian measures are necessary. We are prepared to cooperate with you as you move to find a cure.

Thank you.

INSURANCE AND COMPETITION

STEWART W. KEMP[*]

The insurance industry is the only major American industry which is almost wholly exempt from both the federal antitrust laws and federal regulation of its product. Subject to regulation of varying types at the state level, insurance has not wholly escaped the scrutiny of the deregulation advocates who have precipitated fundamental transformations of long-regulated industries like air transportation and trucking. Spirited debate continues among advocates of near-total non-regulation of pricing and distribution, proponents of governmental action to promote availability of coverage, disclosure of price information, and accuracy and equity of individual rates, and defenders of the status quo.

In contrast to other regulated industries, no consensus behind any one proposal has crystallized. The complexity of insurance products and markets, in combination with uncertainties as to the actual effects of competitive forces on them, are in large part responsible. It is the objective of this article to attempt a systematic functional analysis of the operation of competition in insurance markets and to suggest implications for public policy.

Following a brief summary of recent developments in this area, the effects of competitive forces on both insurer expenses of doing business and incurred losses are analyzed. Next the four basic forms that competition can take in insurance markets are discussed: adjustment of price and service, product differentiation, motivation of intermediaries, and selection of risks. The implications of the unusual nature of the insurance product—costs that are unknown at the time of sale and that vary with the purchaser—are then assessed in several areas: efficiency of resource allocation; creation of incentives for loss reduction and retention; third-party effects; incidence of environmental hazards; and conflicts between market forces and the public interest. Finally, conclusions are presented as to public policies appropriate to the distribution and pricing of insurance.

I. BACKGROUND

Enacted in 1945, the McCarran-Ferguson Act provides that the Sherman, Clayton, and Federal Trade Commission Acts shall be applicable to the business of insurance to the extent that such business is not regulated by State law.[1] With the exception of agreements or acts of boycott, coercion, or intimidation, insurers have been largely exempted from the provisions of the antitrust laws by virtue of extensive regulatory schemes enacted in virtually all the states.

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At the time the McCarran-Ferguson Act was written into law, insurance ratemaking for property-liability lines was largely in the hands of industry-controlled rate bureaus.[2] In the two-thirds of the states which had rating laws at that time, effective control over private bureau rates was often non-existent.[3] By 1951, in response to McCarran-Ferguson, all states had adopted fire and casualty rating laws, generally requiring prior approval of insurance rates by state officials.[4] Although the model statutes on which most state laws were based contained a provision allowing member companies to deviate from bureau rates, independent behavior was difficult and many insurers adhered to agreements not to deviate from bureau rates.[5] Over the past generation, however, more flexible rating systems have evolved. A number of states have introduced varying degrees of competition in their rating laws. While a majority of states continue to use the prior approval mechanism, it has become easier for individual companies to file independently.[6] At the same time, these laws have been administered by most states in a manner designed to allow companies substantial latitude.[7] At least 17 states now utilitize various "open competition" statutes which permit insurers to introduce new rates without delay, while one—Illinois—has no rating law at all.[8]

The property-liability industry has undergone a significant change since the passage of the McCarran-Ferguson Act in 1945.[9] Since the industry is no longer dominated by tight cartels or uniform regulatory supervision of collective ratemaking, the justification for antitrust immunity must be evaluated in light of present conditions. With assets of $677 billion and annual premiums of about $193 billion, the insurance industry is a major sector of the American economy.[10] Its impact on consumers is great, and the quality of its performance is of substantial national importance.

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[1] 15 U.S.C. §1011 *et seq.*

[2] Report of the National Commission for the Review of Antitrust Laws and Procedures (Washington, D.C. 1979) [hereinafter cited as Commission Report], p. 230.

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Id.* at 231.

[7] *Id.*

[8] *Id.*

[9] *Id.*

The scope of this immunity, and the proper role of competition in insurance markets, has stimulated much debate in recent years. In January 1977, the U.S. Department of Justice released its "Report on Pricing and Marketing of Insurance."[11] Culminating a year and one half of study, the Report concluded that "an alternative scheme of regulation, without McCarran Act antitrust protection, would be in the public interest."[12] It found that existing antitrust precedent would permit necessary collective activities such as joint loss data collection and insurance pools and reinsurance agreements.[13] The Report determined the insurance industry to be favorably structured for competition and concluded that price competition would be an effective alternative to state run regulation.[14]

Following the Justice Department study, the National Commission for the Review of Antitrust Laws and Procedures released its report in January 1979, a full chapter of which considered the McCarran-Ferguson Act exemption at length. The Commission, composed of a diverse group of antitrust experts from the legislative, judicial and executive branches of government, the academic world, and private law practice, concluded almost unanimously that the current broad antitrust immunity should be repealed.[15] In its stead the Commission recommended narrowly drawn legislation to affirm the lawfulness of a limited number of essential collective activities.[16]

The Commission recommended that the states place "maximum reliance on competition in pursuing their regulatory objectives."[17] The Commission observed that the industry is characterized by a lack of significant economies of scale, relatively standardized policies in many lines, and low barriers to entry.[18] Nationally, the industry is not heavily concentrated; the eight largest (of about 2,886) property/liability insurers accounted for 31.9% of total industry premiums in 1977, and 38.7% of auto premiums.[19] The Commission did not, however, recommend total deregulation of the industry with sole reliance on unfettered competition. Rather it proposed additional study of economic regulation of insurance, including: "(a) the appropriate regulatory response to problems of equity and discrimination in insurance rates; and (b) the relationship between such regulation and the availability and affordability of insurance."[20]

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[10] *Id.* at 228. A.M. Best Co., Aggregates and Averages (1981).

[11] A Report of the U.S. Department of Justice to the Task Group on Antitrust Immunities: The Pricing and Marketing of Insurance (Washington, D.C. 1977).

[12] *Id.* at viii.

[13] *Id.*

[14] *Id.* at xi.

[15] Commission Report at 225.

[16] *Id.*

[17] *Id.*

[18] *Id.* at 229.

[19] *Id.*

Although it favored almost complete removal of governmental controls in other traditionally regulated industries, such as trucking, the Commission indentified characteristics of the insurance industry which suggested a potentially positive role for certain types of regulation. The Commission noted the phenomenon of "selection competition," the process by which insurers in competitive insurance markets tend to classify people by risk groups.[21] It also described concerns that unregulated competition was not compatible with social objectives of equity and fairness. The Commission concluded that such concerns were legitimate and that they should be evaluated carefully; it confessed to inadequate resources to undertake the project itself.[22]

Numerous other studies over the past three years have addressed the issue of regulation versus open competition in insurance markets. State and Federal regulatory agencies as well as individual insurers have contributed to the effort. Probably the three most significant recent studies are the analysis of state insurance regulation: a release by the General Accounting Office in October, 1979;[23] a May, 1979 SRI International Report commissioned by Commercial Union Assurance Companies;[24] and a report prepared in May, 1980 by the Advisory Committee on Competitive Rating to the National Association of Insurance Commissioners (NAIC).[25]

The General Accounting Office Report, "Issues and Needed Improvements in State Regulation of the Insurance Business,"[26] addressed regulatory responses to competitive rating issues in auto insurance as well as providing an evaluation of state insurance regulation in general. The GAO Report evaluated relative price levels in states which regulated auto insurance rates in comparison with those with open competition laws. The GAO found, on the average, that there is little difference in auto insurance prices, as measured by loss ratios, between states that regulate insurance rates and those that do not.[27] The GAO concluded that:

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[20] *Id.* at 225.

[21] *Id.* at 241.

[22] *Id.* at 241, 243.

[23] Comptroller General of the United States, "Issues and Needed Improvements in State Regulation of the Insurance Business," (General Accounting Office, Washington, D.C. 1979) [hereinafter cited as "GAO Report"].

[24] SRI International, "Choice of a Regulatory Environment for Automobile Insurance," (Final Report, Menlo Park, CA, 1979) [hereinafter cited as "1979 SRI Report"].

[25] "Report of the Advisory Committee on Competitive Rating to the National Association of Insurance Commissioners," (1980) [hereinafter cited as NAIC Advisory Committee Report].

[26] *Id.* at 63, n.23.

> base insurance rates in the voluntary private passenger automobile insurance market need not be regulated if there is much greater regulatory action to provide consumers with enough information to make the competitive market work efficiently. However, . . . regulation may be necessary to prevent the use of rate differences that constitute unfair discrimination.[28]

Unlike the SRI and NAIC studies cited earlier, the GAO drew a careful distinction between base rates and differentials by classification and territory. Separate chapters deal with those issues and the problem of availability of coverage for those drivers whom insurers do not wish to underwrite voluntarily at standard rates. The GAO concluded that state regulators needed to undertake independent evaluations of classification and territorial rating plans, in both open rating and prior approval states, and to take stronger actions to address problems of availability.[29] Included in the GAO Report were extensive data measuring rate differentials, availability problems, and other indicia of market performance.

The SRI Report considered the operation of competition in private passenger automobile insurance. Finding the industry structured to support competition, the Report recommended the elimination of price regulation and minimum "interference" in risk assessment.[30] Other recommendations included the support of continuity in the market, continued use of residual market mechanisms (at "full, actuarially based" prices) to address availability problems, and provision of product information to help customers in making informed decisions.[31] Absent from the recommendations (other than support for further research) were proposals involving any regulatory intervention to address issues of fairness, inaccurate pricing, or other potential problems of market failure resulting from unfettered competition.[32]

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[27] GAO Report at 100.

[28] GAO Report (Executive Summary) at 25.

[29] *Id.*, Chapters 6-8.

[30] 1979 SRI Report at 12.

[31] *Id.* at 12-14.

[32] *Id.*

The NAIC Committee report took much the same point of view as the SRI study. Composed of 21 industry representatives and two members of consumer groups, the Committee favored complete deregulation of auto insurance pricing.[33] Backing off from an earlier exposure draft put forward by the NAIC staff, the Committee opposed requiring insurers to accept all risks at the posted price for each classification and territory.[34] It also proposed no limitations on underwriting or classification selectivity, or rate differentials by class or territory.[35] Disagreeing with the National Antitrust Commission, the Committee endorsed collective rate-making through the promulgation of manual rates by rating bureaus.[36]

The property/liability industry generally favors nonregulation of rates, classifications and related areas. Nonetheless it almost universally opposes any amendment to the McCarran-Ferguson Act, whether to limit the scope of the antitrust immunity or to establish any measure of federal regulation.[37] The position generally taken is that the insurance industry, unlike most other sectors of the economy, should be subject to neither economic regulation by any level of government nor the standards of independent, competitive action established by the antitrust laws.

On March 25, 1980, Senator Howard M. Metzenbaum, then Chairman of the Senate Judiciary Subcommittee on Antitrust, Monopoly and Business Rights, introduced the Insurance Compeition Improvement Act, S.2474.[38] It constitutes the first federal bill to deal comprehensively with the issue of the role of competition in insurance markets. Going beyond a curtailment of the antitrust immunity alone, the bill would establish standards to promote competition in auto and homeowners insurance on the basis of price and service. The summary accompanying the bill provided the following explanation:

> This bill has three primary purposes. The first is to limit the sweeping antitrust immunity granted the business of insurance by the McCarran-Ferguson Act. The second is to promote competition in the pricing of automobile and property insur-

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[33] NAIC Advisory Committee Report, Chapter III.

[34] *Id.* at 35.

[35] *Id.* at 31.

[36] *Id.* at 63.

[37] *See, e.g., Insurance Competition Improvement Act*: Hearings on S.2474 Before the Subcommittee on Antitrust, Monopoly and Business Rights of the Senate Judiciary Committee, 96th Congress, 2d Session (1980) (statement of Andre Maisonpierre, Alliance of American Insurers).

[38] *Congressional Record*, S.2474, 96th Congress, 2d Session, 126 Cong. Rec. S.2977 (1980).

> ance on an average rate level basis. The third is to improve the operation of competition by establishing minimum standards to prohibit unfairly discriminatory classifications in insurance pricing, to ensure full availability of automobile and property coverage, and to eliminate unfair and excessive rate differentials among insureds.[39]

The bill represents a considered response to the unique dynamics of competitive insurance markets. The standards in the bill are broad rules which, like the antitrust laws themselves, would act as constraints within which market forces would freely operate, rather than as direct economic regulation.

Competitive forces can take different forms depending on the nature of products as well as market structure. Functional analysis is necessary in order to test various market outcomes against public policy criteria of efficiency and equity. Only blanket reliance on nonregulation as unchallengable doctrine can support the proposition that all forms of corporate rivalry are automatically in the public interest.

For competitive markets to function efficiently, certain preconditions must be satisfied. All firms must be price takers. In other words, the firm must act as if it can alter its rate of production and sales within any feasible range without having any significant effect on the price of the product it sells. The industry must also be characterized by freedom of entry and exit. This condition implies that neither economic, legal, nor institutional barriers prohibit entry or exit from the market.[40] In order for competition to function, buyers must be reasonably well informed as to prices and sellers as to costs. In addition, buyers must be willing and able to buy at market prices and sellers must be willing and able to sell. Private costs must fully reflect all costs to society, and private benefits must reflect all benefits accruing to society as a whole.

As any micro-economics textbook explains, satisfaction of these conditions results in an equilibrium in which price equals marginal cost equals minimum average long run total cost.[41] In this situation no one person can be made better off without someone else made worse off. And production occurs at the scale where resources are utilized at peak efficiency.

It is essential that any market involved be carefully analyzed to determine whether the preconditions have been met. Any material deviation from them will undercut the validity of policy recommendations derived from the unadjusted competitive model. Where deviations are significant, policies must reflect actual market conditions, not theoretical abstracts. A functional analysis of the operation of competition in particular markets is therefore necessary to avoid unsuitable, or even harmful, policies.

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[39] *Id.* at S.2980.

[40] R. LIPSEY AND P. STEINER, ECONOMICS (4th ed. 1975) at 269.

[41] *Id.* at 277.

The special characteristics of insurance markets underscore the importance of such an analysis. Insurance is virtually unique among consumer products and services in two major respects: its costs are to a large extent unknown at the time of sale, and its costs vary with the purchaser. With the limited exception of credit, no other major good or service shares these characteristics. Their existence opens up an array of competitive methods and strategies which simply do not exist in other markets. Not only can insurers compete on the bases of price and quality (or service) which underlie the economists' model, they can compete by refusing to write, or surcharging, individuals they perceive to be worse than average. Underwriting and classification techniques which insurers have developed intensively create a competitive dynamic virtually without parallel in other markets. Informed public policy must be based on careful analysis of this process.

Imperfect knowledge of costs likewise produces special market dynamics. In normal competitive markets, the market price is determined by the intersection of market supply and demand curves. The market supply curve represents the aggregate quantities firms are willing to supply at different prices; these depend directly on the firms' costs of production embodied in their cost curves. The market demand curve represents the aggregate quantities which all consumers in the market will buy at various prices.

Because insurers' costs are not known, marginal and average total costs curves are indeterminate. The supply curves for both firm and industry are similarly indeterminate and market equilibrium at fixed prices and quantities does not follow as in the textbook case. To the extent that insurers are averse to risk resulting from uncertainty about costs, they will set higher prices than would result in a competitive equilibrium where costs are known. Where costs are considered extremely uncertain, as in cases where loss patterns are changing rapidly or where inadequate experience exists to form reasonable basis for prediction, market failure may become complete. In such markets insurers simply cease to offer coverage at any price, supply curves disappear rather than merely rise, and no market price exists.

A third singular characteristic of insurer costs is the effect of insurer prices. High price levels may increase costs by increasing the frequency of claims, as in padded or fraudulent claims filed by policyholders resentful of high premiums. And pricing structures may reduce costs by creating incentives for patterns of conduct likely to reduce losses, such as individual merit rating plans.

The very existence of insurance, moreover, distorts cost structures in markets for insured goods and services. Insured individuals (or persons to whom insureds are liable) are likely to consume additional insured goods and services when the marginal cost to them is nominal or nil. Sick persons with health insurance, for example, may utilize greater quantities of medical services, and more expensive services, than they would if paying directly. And providers, knowing a third party is footing the bill, may charge more.

In addition to the special effects flowing from the nature of costs, insurance markets are open to other forms of non-price competition practiced in non-insurance markets, especially price-rigid oligopolies. These methods include product differentiation (e.g., proliferation of minor policy variations), quality erosion (e.g., refusal to pay certain claims or to establish adequate reserves against claims), non-disclosure of key information (e.g., failure to provide rates of return on cash value life insurance), and service (e.g., rapid response to customer inquiries). The extensive use of intermediaries (agents and brokers) in the insurance business also stimulates "reverse competition," the process whereby producers compete to motivate intermediaries rather than consumers.

Overlying all forms of competition in insurance markets are pervasive external effects; insurance decisions affect policyholders, persons to whom they become liable, and beneficiaries. Many forms of insurance are required by either law or economic necessity; concern about the effects of insurer marketing practices extends beyond economic efficiency to issues of availability and equity in the sale and pricing of essential coverage.

As this quick overview suggests, competition can take many forms in insurance markets. Not every one produces advantages in terms of economic efficiency or social welfare. Despite the recent spate of proposals for total deregulation of insurance products, there is no assurance that every form of corporate rivalry is desirable or efficient. The following sections analyze in greater detail the forms competition can take in insurance markets.

II. INSURER EXPENSES

Increased emphasis on competition can bring benefits to consumers in a number of ways. Foremost is improved efficiency in the delivery of the insurance product. Typically, 30 to 40 cents of every property-casualty premium dollar goes to cover the insurer's expenses of doing business: general administration, claim adjustment, and acquisition. There is little doubt that insurance companies vary widely in the relative efficiency with which they process policies and adjust claims. Some companies incur lower acquisition costs by selling policies directly to customers rather than through agents; others reduce costs by adjusting commission rates or other aspects of their relationships with agents, such as greater integration of billing, policy delivery, and claim adjustment procedures. Rating systems which depend on standard bureau rates or pooled expense data, however, provide no benefit to customers of the lower-cost companies. More importantly, no incentive is established for consumers to switch from high-cost to low-cost companies, thereby exerting pressure on inefficient companies either to reduce costs or exit from the industry. At the same time, the incentive for efficient firms to expand their market shares or to enter *de novo* is reduced. Thus the achievement of the fundamental benefit of competition to consumers—pricing at minimum cost—is frustrated by rating systems in which prices are based on standard rates or pooled expense data. The use of deviations from standard rates, to the extent actually based on expense differentials, mitigates the severity of the problem. But independent, non-collusive rates which reflect insurers' own experience maximize the benefits to be gained from competitive pressures for efficiency.

Rating systems which automatically base future rates on past expenses actually build in an incentive in the opposite direction, to increase expenses so as to create a larger base for future rates. The effect of this incentive is increased when a rating system prevents an insurer from reaping the benefits of its lower expenses in lower rates, as is the case under restrictive rate regulatory schemes. While short-run gains accrue, of course, to insurers who constrain costs in the face of constant revenues, the opposing long-run incentive to maintain a high expense rate base for regulatory rate-making purposes operates at cross-purposes. Regulatory systems which base expense allowances on past expenses provide virtual assurance that all incurred expenses, regardless of merit, will be passed through to consumers. In many cases the use of an automatic percentage loading for the expense component of the rate, based broadly on past incurred expenses, will result in even greater increases in allowed expense dollars than the growth of actual expenditures would support. If losses rise at a rate faster than the expenses of doing business, a constant percentage loading results in more rapid growth of expense dollars than real needs could justify. If, for example, losses for a line of insurance over one year rise by twenty-five percent, under the extensively used percentage loading rate-making method, expense allowances would also rise by twenty-five percent. This would happen even if the relevant rate of inflation for wages and other costs of doing business were six or eight percent.

Increased emphasis on price competition would encourage the replacement of automatic regulatory expense pass-through and arbitrary loadings in excess of actual needs with the disciplining forces of the open market. Consumers would clearly benefit from such a change.

III. INSURER LOSSES

Other than the portion applied to cover expenses, most of the premium dollar goes to pay for expected losses. The difference is an allowance to reflect return on capital and investment income. Unlike expenses, however, losses are largely outside the control of insurers. They are also unknown at the time rates are made. These two facts set insurance apart from virtually all other industries and dramatically affect the outcome of competition on market conduct and performance.

Insurers can compete on the basis of price and service, product differentiation, the payment of higher commissions or other compensation to agents and other intermediaries, and risk selection through underwriting and classification selectivity.

Competition on the basis of price, of course, is widely favored by economists and is a major public policy objective of the antitrust laws. Through price competition, if all firms are price-takers and entry and exit of firms are not constrained, price will equal marginal cost—the cost to society of the foregone resources utilized in production. In addition, the pressures of competition will hold prices down to minimum average costs. Thus effective competition assures society of the optimal allocation of resources, on efficiency grounds, and assures that no firm receives excess profits beyond a normal return on capital. Necessary to the successful operation of the competitive system, however, is knowledge of costs. If costs are not known, prices cannot be set to equal them and the solution of the pricing problem becomes indeterminate. A key characteristic of insurance, of course, is that loss costs are not known at the time the product is sold. In addition, unlike those of most products and services, insurance costs vary with the purchaser.

Costs will always be uncertain to a greater or lesser extent because knowledge of the future is never perfect. The primary technique available to insurers for predicting future loss costs is pooling the loss data from a recent period for a number of risks so as to obtain reliable estimates of the average loss for each member of the group, or exposure. In actuarial terms the degree of predictability given by the pooled data is its credibility. The larger the pool of data, the more certain one can be that the mean of the sample pool is close to the mean of the total population, provided that individual losses and exposures are independent.

Knowledge of mean losses in a past year, however, does not guarantee knowledge of what they will be in a future year. Typically the projection period during which rates will be in effect lags the base period from which the data base is generated by two or three years or more. During this period, many forces operate on both the frequency of claims (the number per unit exposure per year) and the average cost per claim. Inflation is the most certain of these and is, on a relative basis, easy to predict. Other influences include changes in statutes affecting the scope of insurance coverages or claims behavior by insureds. Examples are the introduction of a merit rating system, a change in the standard of recovery from replacement value less depreciation to actual cash value, or changes in the penalties for fraudulent claims behavior. Variations in the driving environment (such as accident rates, increased law enforcement, or an energy crisis) affect auto insurance claim frequencies, as do increases in gasoline prices and other costs of driving. Changes in claim adjustment practices, especially regarding fraudulent and padded claims, can have a substantial effect on average claim costs. Variations in the incidence of certain crimes, such as auto thefts or house-breakings, substantially affect the frequency of claims under some coverages. Changes in legal standards of liability or in the measurement and awarding of damages also affect losses as do changes in the propensity of injured persons to file claims and lawsuits. In sum, many causal factors, which are either unknown or difficult to predict at the time rates are made, affect the frequency and size of actual losses incurred when the rates are in effect. No matter how extensive the loss data available from the recent past, it is a difficult and highly judgmental task to estimate future losses.

The process of estimating the impact of all causal phenomena on the data base is called trending. The simple, almost mechanical name belies the complexity of the judgments that underlie the estimation of trend factors to translate the base-year data into the loss component of future-year rates, even if simple curve-fitting techniques are relied on. The more volatile recent experience has been, and the more changes there are in the loss environment, the more uncertain becomes the estimation of trend factors. By implication insurers have less certainty that any rate level will be adequate.

A good illustration of these principles is provided by the experience in most states during the last few years with medical malpractice insurance. Loss data for the early 1970's showed sharp increases in both the frequency and severity of malpractice claims, apparently reflecting among other factors increased litigiousness on the part of injured patients and higher damage awards in cases that went to verdict. Since the lag between a medical injury and the final award of damages may be five or even ten years, the trend period is much longer than in fast-closing lines like auto physical damage and homeowners. Consequently, the uncertainties present in projecting from recent loss data are even greater in this line. Insurers responded first by using very conservative trend factors. Although this practice led to a doubling and tripling of rates in many states, most insurers still did not feel sufficiently assured that their rates would turn out to be adequate. As a result, in a number of states they ceased writing malpractice insurance altogether, despite rates which in many cases were adequate to cover current losses two or three times over. It became necessary in such instances for state governments to establish mandatory pooling arrangements, such as joint underwriting associations, to ensure continued availability of this coverage

The uncertainty inherent in rate-making is key to the operation of competition. Insurers are not indifferent between rates which are a given percentage over adequacy and rates of the same distance below. Overshooting the mark is fine—profits are high, bonuses can be paid, and the company grows. But such success is not necessary to the company's basic welfare. Inadequacy, on the other hand, can threaten the existence of the company. Since claims are based on contractual obligations, deficits must be made up either by drawing down surplus or paring expenses. The former weakens the company's financial health while reducing capacity, and the latter implies foregoing pay raises or reducing the number of employees, or both. Neither is palatable. Consequently, insurers tend to make rates conservatively. For example, many insurers routinely load rates with an additional several percent for "contingencies," even though all expected losses and expenses have already been fully accounted for in other components of the rates. The greater the uncertainty, and the more averse to risk the insurer, the more cautious will be the rate-making projections. And rates incorporating these projections will be systematically excessive. In stable insurance environments, on the other hand, where the loss experience does not vary substantially from year to year, the problem of loading rates for uncertainty and systematic risk is diminished.

If insurance is systematically overpriced, one might expect some companies to undercut the prevailing price. Unless, however, some insurers are significantly less risk-averse than others, this is unlikely to happen. Although insurers are in business to pool large numbers of small independent risks, the reluctance to assume large, non-diversifiable risk appears to be near-universal. In fact, the primary purpose of rate regulatory proceedings designed to prevent excessive rates is to provide a non-insurer perspective on what rates should be. Sometimes the differences between insurers (or their bureaus) and state agencies on trend factors alone can be ten or twenty percent of total rate level. While some portion of insurer conservatism may be explained as padding anticipatory of regulatory challenge, the overriding concern for rate adequacy in the face of an uncertain future, as demonstrated by rates employed where such challenge is not possible, is the primary factor.

Despite the complications caused by uncertain costs, price competition can have at least one direct benefit on the loss component: the encouragement of loss control. For a given year, the average loss per insured, or pure premium, varies among insurers for four separate reasons: (1) differences in the distribution of insureds by class, territory and other rating variables; (2) differences in underwriting practices; (3) random variations in claim frequencies and the average cost of claims; and (4) systematic differences in the claim adjustment practices of insurers, especially with respect to padded and fraudulent claims. The first difference reflects the fact that some companies have higher concentrations of business in high-loss areas. Normalization to the standard statewide mix of business eliminates discrepancies from this source. The second difference reflects variations in judgmental screening practices. The third difference, random variation, reflects the effects of chance on the loss experience of different insurers' books of business. The larger the books of business, the lower the variance resulting from random effects. The fourth difference, however, is of great significance in analyzing the effects of competitive rating.

The purpose of insurance is indemnification—to make the insured whole for the loss suffered. Its purpose is not to enrich insureds beyond payment for losses actually incurred. Increasing numbers of insureds, however, appear to be using the claim mechanism as a means to get back more than they fairly deserve. Stimulated in part by resentment of high premiums and in part by a sense that no individual person is really paying, such policyholders overstate the amount of loss, pad claims to cover deductibles, or even invent wholly fictitious losses or damages. Informed observers have estimated the incidence of fraud and padding to be ten or twenty percent of all claims for some lines (such as auto) in some areas. Companies which do a better job of policing claims will have, on average, lower loss costs. Under a rating system in which rates vary by company and are based on each company's own experience, policyholders will reap the benefit of more rigorous loss adjustment practices in the form of lower rates. Under a competitive system in which rates are based on each insurer's own loss experience, incentives are created for companies to control loss costs. The tighter their claim adjustment practices, the lower will be their rates and hence the better their competitive position. Consumers will be attracted to switch to the lower-rated, more tightly managed companies, and insurers who fail to work aggressively to limit claim payments to indemnification will come under pressure in the marketplace. At the same time, insurers who unfairly deny or delay payment on legitimate claims will be penalized as consumers switch to other companies and inform acquaintances about their experiences.

Competition will establish salutary incentives for loss control to the extent that losses are within the control of insurers. It is essential to note, however, that this incentive is severely diluted if loss data are pooled. Such pooling wipes out the differences among companies and therefore to a large extent this incentive to control loss costs. The wide use of pooling heretofore probably explains, in part, the limited interest in policing claims displayed in many sectors of the property/casualty insurance industry. Under pooled loss data systems—especially with uniform rates—an opposing incentive is created. Insurers will gain in the future through higher rates resulting from higher losses in the rate base. Virtually every actuary in the industry, and almost every regulatory agency that reviews rates, allows all paid losses in full as the starting point from which rates are made. Thus insurers are generally assured that if they overpay claims in one year they will effectively recoup the money two or three years later. Under a competitive system in which rates are based on the losses and expenses of individual companies, this recoupment effect is also present to some extent in the rate-making process. Competitive pressure generated by lower-cost companies, however, can be expected to provide powerful constraints on the freedom of lax insurers to recover inflated claim costs from future policyholders.

IV. PRICE AND PRODUCT INFORMATION

A final issue necessary to consider in evaluating direct price competition in property/casualty insurance is the availability to consumers of reasonably complete price and product information. Most economists are in agreement that the availability of such information, without substantial cost to the consumer, is a necessary precondition to the successful operation of competitive markets. The availability of such information is of special importance in insurance because of the complexity of the product, the absence of tangible physical substance (beyond the policy form), and the logistics of computing rates for multiple coverages.

The insurance product is generally defined by a complex array of coverages, limitations, exclusions, conditions, and assorted specifications, in many cases contained in small print in a mass of formidable legal prose known as a policy. There is little doubt that many consumers are ill-informed about the scope of most insurance policies. Where policy forms vary substantially, especially in the scope of coverage—as, for example, in the individual health area—price comparisons become virtually impossible. Competition based on price differentials is therefore frustrated. Where coverage and policy provisions are relatively standard, however, as is usually the case the automobile and homeowners lines, price comparisons can be made meaningfully and competition can function reasonably well, even in the absence of detailed knowledge of policy provisions among consumers. Nonetheless, easily readable policy forms, buyer's guides, and easily understood policy summaries are highly desireable to improve the functioning of competition. In lines of insurance in which the scope of coverages varies substantially, they are indispensable.

In some lines of insurance—notably automobile—the total premium for a policy is the sum of premiums for a number of coverages. For a particular consumer the rate for each coverage depends on a number of variables, such as (depending on the jurisdiction) the principal place of garaging, the extent of business use, use in commuting, the annual mileage, make, model and age of the vehicle, age and sex of each driver, and the extent of use by each driver. The computation of rates for a particular insured is a somewhat complex task which requires time and effort on the part of the insurance company's representative. For consumers to shop effectively, it must be possible for them to obtain accurate price quotations from a number of companies without being required to expend undue time and effort. Assurance of reasonable access to comparative price information is a necessary precondition to the successful operation of price competition.

On the basis of the foregoing analysis, it may be concluded that price competition in property/casualty insurance can offer the benefits in the areas of reducing inefficient insurer expenses and overpayments of claims. At the same time, there are significant risks that a shift in public policy in favor of increased competition might be used simply as a means of raising rates beyond the level of previously imposed regulatory limits, especially in less stable lines of insurance and in the more volatile states. On balance, the existing trend in state regulation toward greater price competition should be encouraged for base rates, provided that market transparency is improved by widespread distribution of specific price information, that collusion in setting rates is prohibited, and that rate differentials among insureds are controlled. Because of the special characteristics of the insurance product, however, it is essential that regulatory authority remain in place to address possible shortcomings experienced under the operation of competition.

V. COMPETITION BY PRODUCT DIFFERENTIATION

Strategies of variation in the quality, style, details, and packaging of consumer products are commonly found by economists who study oligopolies characterized by price rigidities. This type of market behavior tends to result in substantial allocations of resources to minor product alterations of little social utility, regardless of benefits which may accrue to individual firms in preserving or enhancing market shares. At the same time, price competition tends to languish and price levels tend to remain higher than they would be if pricing decisions were actively influenced by keen competitive pressures.

Product differentiation in insurance generally takes the form of minor changes in the scope of coverage. This process has occurred extensively in health, and, to a lesser extent, in life insurance. Most property/casualty insurers, however, use relatively standard policies, especially in the major consumer lines of auto and homeowners. Product differentiation is especially important in insurance, because its existence on a wide scale largely thwarts meaningful price comparisons and therefore price competition. This effect is especially visible in individual health insurance. There is no question that opportunities should be preserved and increased for product innovation which meets genuine needs. But as increased emphasis is placed on competition in insurance as a matter of public policy, it becomes increasingly important to control wasteful product differentiation and to provide full and accurate coverage information to consumers. While different products are appropriate to meet real variations in consumer needs, the proliferation of hundreds or thousands of minor variations serves largely to generate hopeless confusion.

VI. REVERSE COMPETITION

This term describes the process which occurs when insurance companies compete for profitable business by striving to attract and motivate agents, brokers, and other intermediaries. The usual form is the payment of higher commissions and other inducements to agents. Historically it was this kind of competition which originally generated pressures for regulation against "ruinous competition." In today's world of large companies and relatively small agencies, however, reverse competition is no longer as major a concern in fire and casualty insurance, although it remains widespread in the substandard market. Reverse competition dominates certain relatively low-volume lines of insurance, such as credit life and property, in which intermediaries (typically financial institutions or retailers rather than insurance agents) rather than consumers largely control the purchasing decision. The phenomenon is less pronounced, but nonetheless of great significance, in ordinary life insurance. In that line—where the conventional wisdom is that life insurance is sold rather than bought—commissions to agents in most companies are at least 55% of first-year premiums for whole life policies. For the many companies not licensed to do business in New York, comparable rates run to 75 or even 100%. In large part as a result of acquisition costs of such orders of magnitude, rates of return of policyholders on the savings element of cash value policies are typically much lower than alternative savings and investment vehicles.[42] The Federal Trade Commission recently reported that the average 20-year rate of return on $25,000 non-participating policies sold in 1977 was approximately 2.5%.[43] For dividend-paying policies, the average 20-year rate of return for the same year was 4.12%.[44] For both types of policies, yields were substantially below zero for policies held less than five years. Care must be exercised as the emphasis on competition increases, so that it does not take this form. Not only do consumers receive no benefit, but the increases in acquisition costs raise the costs of coverage unnecessarily. In extreme cases, as happened historically, insurer solvency may be threatened.

VII. COMPETITION BY RISK SELECTION

This form of competition is characterized by efforts of insurance companies to assemble the "best" clientele, or book of business, possible. The defining characteristic of the sought-after book of business is the lowest possible loss ratio, or ratio of losses to premiums. To the extent that one company can out-select its rivals while using the same rate structure, it will be more profitable. One insurance company executive described the process as follows:

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[42] Federal Trade Commission, "Life Insurance Cost Disclosure" (Staff Report, 1979), p. 49.

[43] *Id.* at 45.

[44] *Id.* at 55.

> Competition is best demonstrated from the manner in which we seek out and solicit the best possible customers, those persons who manifest the lowest propensity for loss. But one of the unfortunate effects of competition among insurers is that we really do not compete for the marginal or higher risk persons. What remains then is termed as the residual insurance market.[45]

The risk selection process has two dimensions: underwriting and classification. For a given rate category, insurers seek to pick out from all prospective insureds those whom they feel have lower-than-average expected losses and to exclude those perceived to be "bad" risks. Underwriting manuals, supplemented by the judgment of individual underwriters, are the primary tools for the distinctions drawn by companies among prospective insureds on a non-statistical basis. Senator Metzenbaum described the use of underwriting guidelines on the opening day of hearings he chaired in January 1978 on discrimination by property and casualty insurance companies:

> One final point in connection with consumer problems in property insurance—an examining of underwriting guidelines of property insurance companies reveals some extremely subjective underwriting criteria. The manual of one group of companies characterizes as a bad risk a consumer who "can be seen sitting on his front porch without his shirt" or a homeowner who is "just plain ornery." On that basis, maybe a number of us in Congress fall into the bad-risk category. Are these fair or even measurable bases for making essential insurance decisions?
>
> With regard to auto insurance, various company underwriting guides either prohibit the sale of auto insurance to categories of persons such as divorcees, unmarried persons, cooks, longshoremen, military personnel, musicians, unskilled manual laborers, and professional athletes or require that persons in such categories be specially scrutinized before they are accepted as insureds. Quite often they are given high rates when they are so accepted. Consumers who are denied auto insurance in the so-called standard and preferred markets are consigned to nonstandard rates or to "assigned risk" pools. Many consumers are insured at non-standard rates 35 to 75 percent higher than standard levels without even knowing it.[46]

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[45] *Insurance Advocate*, July 28, 1973 (Leo J. Jordan, Vice President, State Farm Insurance Companies).

[46] Rights and Remedies of Insurance Policyholders: Hearings Before the Subcommittee on Citizens and Shareholders Rights and Remedies of the Senate Subcommittee on the Judiciary, 95th Congress, 2d Session (Part 1, Jan. 1978) at 3.

James M. Stone, former Insurance Commissioner of Massachusetts, considered the compatibility of competition and regulation in detail in his landmark decision on 1978 insurance rates, which led to the termination of discrimination on the basis of age, sex and marital status in Massachusetts auto insurance rating.[47] Commissioner Stone concluded that if competition among insurers is to operate in the public interest, it must be a well regulated competition. Writing half a year later on the question whether to renew the current suspension of competitive rating, he considered whether competition in automobile insurance could ever work.[48] He identified three problem areas: competitive pressure to encourage refinement of classification cells and large populations of uninsured drivers while refinement remains imperfect; the tendency of competition to charge those policyholders most likely to be victimized by broad social problems such as theft and congestion for their full costs; and the absence of any mechanism under competition to select classification variables creating positive incentives for loss control. Commissioner Stone concluded: "The principle of spread, the demands of justice and the opportunity for cost control all argue for something other than a simple and unimpeded competitive equilibrium."[49]

The direct result of such practices is the exclusion or surcharging of numerous persons seeking essential insurance coverages. Underwriting practices, unlike rate classifications, are not based on statistical loss differentials. Rather they stem from the subjective opinions and impressions of company underwriters. A major study performed by the Stanford Research Institute found that the predictive value of underwriting was meagre; it explained no more than eight percent of the variance in expected losses of the insured population.[50] Thus, many of the people rejected by underwriters should not have been. The majority of those rejected turn out in fact to have been perfectly good risks; many go for long periods of time without making claims at all. At best underwriting is a highly imperfect attempt to distinguish risks. Its existence flows directly from the fact that the costs of insurance are not known at the time of sale and vary from one purchaser to another.

Beyond the direct consequences to insureds of unavailability or surcharging, underwriting generates expenditures of resources of questionable economic efficiency. Where coverage is mandatory, whether *de jure* as for auto liability insurance or *de facto* as for fire and basic property insurance, applicants for insurance will generally end up with coverage somewhere, whether with another company in the voluntary market or through an assigned risk plan, reinsurance facility, Fair Plan, or other residual market mechanism. In markets where prices are the same, or nearly so, the effect on consumers is small. And expeditures of insurers on underwriting are almost fully a dead-weight loss. Although underwriting may lead to some rearrangement of insureds among insurers, the very low success rate of underwriting, combined with the fact that the underwriting efforts of companies tend to the self-cancelling, indicates that the benefits to society of underwriting in such markets are marginal.

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[47] Comm'r. J. Stone, "Opinion, Findings and Decision on 1978 Automobile Insurance Rates" (Mass. Div. of Ins., 1977) at 172ff.

[48] Comm'r. J. Stone, "Opinion, Findings and Decision on the Operation of Competition Among Motor Vehicle Insurers" (Mass. Div. of Ins., 1978) at 13-18.

[49] *Id.*

[50] Stanford Research Institute, "The Role of Risk Classifications in Property and Casualty Insurance: A Study of the Risk Assessment Process" (Menlo Park, CA, 1976, Final Report) at 49 [hereinafter cited as 1976 SRI Study].

In markets where prices vary substantially and in which exclusion of customers is allowable, the consequences of underwriting to insureds are the inability to secure coverage at prices reflecting their expected losses or to obtain coverage at all; in such markets there is a net welfare loss to society. Similarly, surcharges unjustified by true expected losses will distort consumption patterns away from the optimal. Furthermore, the use of underwriting criteria such as occupation, marital status, or personal characteristics which are not causally related to loss likelihood fails to create meaningful incentives for loss control.

Emphasis on competition exacerbates the social problems caused by underwriting. So long as underwriting achieves—or is perceived as achieving—a degree of risk selection worth its administrative costs, any one company will be under competitive pressure to utilize it if others do. Any single company which fails to underwrite on the basis of widely used criteria runs the risk of getting all the business the others do not want. Even to the limited extent that underwriting is accurate, such a company would be disadvantaged significantly in the marketplace. In order to mitigate the effects of this type of competition, with its accompanying casualties of unavailability and unfair discrimination, broad standards and rules must be established which apply equally to all companies in the market. Government alone can do this, and it is therefore essential that rules and standards be established through law or regulation. Without a suitable framework within which to operate, the forces of competition can lead to destructive rather than constructive results.

Competition through risk classification parallels the underwriting process. Classifications represent groupings for rating purposes which are generally based on statistically different loss experience of such groupings. Commonly used variables in auto insurance include territory, age, sex, and vehicle type. All members of a grouping are charged the group rate regardless of any individual characteristics causally related to expected losses. Typically only a small proportion of drivers in each class—even those most highly rated—actually have claims in a given year. High-rated classes tend to be more heterogeneous in make-up than lower-rated ones, with many low-risk drivers lumped together with high risks. As a result, many drivers are overcharged by being placed in high-rated groupings despite low loss propensities reflected by exemplary driving records.

A number of the variables widely in use today, such as sex and age in auto insurance, are increasingly suspect from the perspective of modern law and mores. Beyond the control of the individual, their use offers no incentive to improve behavior. By penalizing individuals for the conduct of other members of a group with whom they have no direct connection, the use of such variables runs counter to the fundamental principle that each individual be judged on his or her own merits. By analogy to the civil rights laws, it is appropriate for each insured to be considered on an individual basis rather than be disadvantaged by pejorative association with a group based on a superficial characteristic unrelated to individual conduct affecting likelihood of loss.

Competitive forces operate to pressure companies either to charge higher rates for groups with worse-than-average loss experience or to avoid such business at standard rates. Once it is known that a particular group has statistically worse loss experience, any single company that fails to act on that knowledge will get an increasingly large share of that business as other companies either raise rates for that group or refuse to write it. At the same time, every company has strong incentives to find other identifiable groups with better-than-average loss experience. When standard rates are charged, extra profits are earned. As knowledge spreads, discounts are offered or a separate rating class is established. All persons not in the favored group must pay higher rates to offset the discount. The same incentives toward subdivision operate to weed out identifiable groups with higher-than-average losses. One response, mirroring the discounts, is surcharged rates. The other option, however, is refusal to write. The more frequently this happens, the more severe become the problems of market breakdown.

As noted by the National Association of Insurance Commissioners, subdivision of insured populations and increasing classification refinement run counter to the fundamental insurance principle of spreading risk.[51] The natural impetus of competitive rating is toward a system which generates higher and higher rate differentials as classes are increasingly refined. But the more this process occurs, the more the basic principle of spread is undermined. At the same time, as Dr. Joseph Ferreira, former Massachusetts State Rating Bureau actuary-statistician, observed in his 1978 paper on equitable insurance pricing, classification refinement is an "elusive dream."[52] The nexus between known information about groups of people and their expected losses is so thin that the additional explanation of loss variance to be gained from further refinement of classification plans is meagre. In its 1976 study the Stanford Research Institute found that the highly refined ISO 217 class plan explained only 12% of the total expected loss variance for automobile insurance.[53] Merit rating explained an additional 5% while territory accounted for 8%.[54] The SRI study also compared the ISO 217 class plan with simpler alternatives in use elsewhere. A seven-classification plan in use in the early 1960's explained more than 10% while a five-class system formerly used in Canada explained 12%. The study concluded that it may be difficult to find new classification variables that greatly improve the current precision of risk assessment.[55]

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[51] H. P. Hudson, "Presentation on Behalf of the National Association of Insurance Commissioners to the National Commission for the Review of Antitrust Laws and Procedure" (July, 1978).

In view of the diminishing returns available from classification refinement in terms of accuracy, further pressure toward refinement resulting from increased competition will likely prove to be counterproductive. While additional differentiation may improve aggregate accuracy marginally, many individuals will be misclassified as a result. The SRI study found substantial overlaps in the expected loss distributions of differently rated classes. The study estimated, for example, that 28% of males have accident likelihoods lower than the female average while 13% of the females have an accident likelihood greater than the male average.[56] The study further developed strong evidence that the expected loss of a policyholder in a high-risk class has a greater absolute uncertainty (variance) or heterogeneity than the expected loss of a policyholder in a low-risk class.[57] The greater degree of heterogeneity in the high-risk classes implies larger undercharges and overcharges of policyholders in those classes. As overcharges of low-risk policyholders tend to become more frequent and greater in absolute terms with the creation of more and larger high-rated classes, classification errors become increasingly serious concerns. To the extent society is more concerned about large overcharges than undercharges of the same magnitude, a net utility loss is incurred as large overcharges become more frequent.[58]

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[52] J. Ferreira, Jr., "Identifying Equitable Insurance Premiums for Risk Classes: An Alternative to the Classical Approach" in *Automobile Insurance Risk Classification: Equity and Accuracy* (Mass. Div. of Ins., 1978) at 74, 88.

[53] 1976 SRI Study at 49.

[54] *Id.*

[55] *Id.*

[56] *Id.* at 50.

[57] *Id.* at 52.

Insurers setting prices independently under competitive conditions have little, if any, concern about large overcharges of individual policyholders. If all members of a class are charged the class mean rate, insurers will recover the total costs of writing that class of business. If rates for a high-rated class are set below the mean in order to reduce the size of overcharges, insurers will tend to be reluctant to write that class of business. Therefore, availability problems will increase. In order to avoid an influx of business from a particular class, each insurer acting independently must charge at least the class mean rate. Thus, any single insurer which tries on its own to set prices which include tempering to mitigate large overcharges will suffer adverse consequences in the marketplace. Competitive forces which encourage more refined classification and underwriting policies inevitably exacerbate the problem of inequitable and inaccurate pricing.[59]

VIII. ACTUARIALLY FAIR PRICING

The term "actuarially fair pricing" is frequently used to describe a pricing system wherein every member of each statistically identifiable group is priced at the mean expected loss of the group (with a reasonable allowance for expenses and profits).[60] Any deviation from this method is frequently described as the subsidization of one class by another.

This description is loosely based on the broader actuarial principle that fairness and accuracy require pricing each individual risk at its expected loss. Acceptance of this broad principle does not, however, imply that class-mean pricing is more fair—in a purely actuarial sense—than class pricing with tempered differentials or even a flat-rate system. The reason for this seeming paradox is that the fairness of the ultimate case—in which each individual risk is accurately priced—does not imply that one set of inaccurate prices is more fair than another, even if one set of prices (based on more refined classifications) explains a higher proportion of total loss variance than another.

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[58] *See* Ferreira, note 52 *supra*.

[59] *See, e.g.*, "Insurance Redlining: Fact Not Fiction," a Report prepared by the Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin Advisory Committee to the U.S. Commission on Civil Rights (1979) and GAO Report, note 23, *supra*. Data compiled in the GAO Report for auto insurance show that in most states, as of 1976-77, a fourth or more of cars are insured through nonstandard companies or residual market mechanisms or uninsured altogether (GAO Report at 153). The GAO Report also documented extensive auto insurance rate differentials both among states and between voluntary market rates and those in assigned risk plans or with substandard carriers (GAO Report at 156).

[60] *See, e.g.*, 1979 SRI Report, note 24 *supra*, NAIC Advisory Committee Report, note 25 *supra*, and P. Joskow, "Competition and Regulation in the Property/Casualty Insurance Industry," in National Commission for the Review of Antitrust Laws and Procedures, *Reports of Case Studies Project and Advisory Panels* (Vol. II, 1979) at 207-227.

Where fairness is equated with accurate pricing of each individual risk, it must be conceded that any deviation from the ideal pricing pattern will be less fair than the ideal. Some combination of excessive and inadequate rates would have replaced an array of perfectly accurate prices. In the real world, however, perfectly accurate pricing—or even a close approximation—is of course unattainable. Any class plan, no matter how refined, lumps a broad variety of individuals of varying loss expectancies into each single class. Even if the mean loss of the class as a whole is determined with precision, the great majority of class members will be priced inaccurately. Roughly half will be charged too much, and half will be charged too little; only a few who happen to have loss expectancies which coincide with the class mean will be priced accurately.

Setting a different price for members of such a class—or establishing a different price by merging the class with another—will create a different array of overcharges and undercharges. In neither case will the class be "actuarially fairly priced," because in both instances most individuals will be incorrectly rated. The determination as to which class is more nearly "actuarially fairly priced" depends on certain value judgments as to the relative fairness of overcharges and undercharges.

If one assumes that undercharges and overcharges of the same absolute magnitude are equally unfair, and that the unfairness of an overcharge or undercharge varies directly with size, one will conclude that the class-mean price is more nearly fair (or less unfair) than any other price. If, however, one assumes that an overcharge is more unfair than an undercharge of like absolute size, or that the unfairness of large overcharges increases more than proportionately with the size of the overcharge, one will conclude that a price different from the class-mean is more nearly fair.

The resolution of fairness issues of this nature is both complicated and controversial. Suffice it to say, however, that there is no basis to claim that one array of overcharges and undercharges is automatically actuarially fair while another is not.

By the same token, the oft-heard accusation that any deviation from class-mean pricing creates a subsidy is highly misleading. It would be accurate only in the limiting case where the composition of each class within a population was perfectly homogeneous (i.e., each class member had the same loss expectancy). As noted previously, all actuarial groupings of risks include a variety of individuals of varying loss potentials. To adjust class-mean prices—as by tempering or limiting rate differentials between two classes—results in a different pattern of overcharges and undercharges from class-mean pricing. Any subsidies involved flow from those individuals who are overcharged to those who are undercharged. To change the rate for a class changes the magnitudes of the subsidies paid or received by each class member, understanding the subsidy to be the difference between the individual's rate and his expected loss. Needless to say, neither of these groups of individuals corresponds to any actuarial class based on age, sex, marital status, territory or similar variables.

It should be noted that the issue of subsidization in insurance differs sharply from its form in other regulated industries. During the recent debate on airline regulation, for example, much interest focused on "cross-subsidization" of airline service to small cities and towns by means of revenue taken from profitable routes between major cities. In that context, the concept of cross-subsidization is valid because the costs and revenues associated with particular routes can be identified with reasonable accuracy. A subsidy of a route on which revenues do not cover costs can be fairly identified.

In the insurance context, however, the costs associated with particular individuals cannot be ascertained. Since auto and property insurance are generally bought by individuals rather than groups, subsidies simply cannot be identified, much less measured.

Another perspective also casts doubt on the appropriateness of the notion of inter-class subsidization. Actuarial classes exist in most instances in the statistical compilations of insurers alone. Persons grouped together by actuaries typically have taken no steps whatsoever to associate themselves. They do not know other members of the grouping and in no way act in concert or display other indicia of organization or group behavior. The notion of class subsidization has little content where the groupings of individuals into rating classes have no intrinsic validity as groups or organizations.

IX. COMPETITION AND ECONOMIC EFFICIENCY

Class pricing at mean expected losses has sometimes been described as "cost-based pricing." Any deviation from this method, it is suggested, involves a loss in economic efficiency. The use of the term "cost-based pricing" to describe traditional actuarial class-mean pricing is, however, highly misleading because the costs for individual policies are not accurately known.

In order to understand this problem it is important to analyze carefully how insurance pricing affects insurance consumption decisions. Allocative efficiency is obtained when price is set to equal marginal cost. When that condition is met, the cost to society of producing one more of a particular good just equals the gain in utility to the last purchaser. In other words, no one person can be made better off without someone else being made worse off. In the case of insurance, the most efficient pricing system would charge each insured precisely his expected loss. This type of system would eliminate payments higher than expected losses by low-risk insureds and the converse.

Efficiency in insurance pricing has at least four dimensions: the impact of insurance pricing on how much, if any, coverage consumers purchase; its impact on decisions on the purchase—in terms of both quantity and quality—of property to be insured or on the extent of involvement in an insured activity; its impact on the frequency and severity of losses, both incurred and reported, which are insured; and its impact on prices charged and quantities consumed in markets for replacement goods and insured services. Any analysis of the efficiency impact of insurance pricing must consider all four aspects.

With respect to the impact of pricing on coverage purchase decisions, it is essential to analyze consumption from the perspective of the individual. Any insurance pricing system involves an array of overcharges and undercharges to all members of a uniformly priced class. Roughly half the members will be charged less than their expected losses and half will be charged more. The levels of overcharges and undercharges will depend on the degree of variance in the expected loss distribution. Individual coverage decisions will depend on the price of coverage relative to other goods and services, income constraints, the consumer's degree of risk-aversion, the perceived undercharge or overcharge, legal requirements, and general tastes. Elasticities of demand will vary with these factors. Depending on their relative importance, one particular pricing system may or may not yield a more efficient resource allocation than another.

Take, for example, a group of a million drivers, including a subset of 100,000 youthful males. Suppose that the average collision loss per premium (total losses divided by the number of exposures) is $200 for the million drivers as a group but $600 for the youths. Assume further that each group has the same mix of vehicles by car age, make, and model. Omitting consideration of expense and profit loadings, traditional class-mean pricing would yield a premium of

$600 for the youths and about $155 for everyone else, while the one-class charge would be $200 for all. On balance, under the one-class system the young males would pay less, as a group, than their expected losses while all other drivers would pay somewhat more. On the surface one might conclude that youthful males would tend to overconsume collision insurance while other drivers would underconsume it. The validity of this conclusion depends, however, on elasticities of demand and perceptions of undercharges and overcharges. The price differential for non-youthful drivers may well be so small that their purchasing decisions in the great majority of cases would not be affected. Roughly half have expected losses above $155; for many of them the one-class price would be more accurate. For the approximately 50% on the other side of $155, the overcharge is both small in dollar terms and within a reasonable range of uncertainty.

The situation among the youthful males is quite different. At the $600 price many class members—perhaps a majority—may be significantly overcharged. Most under-25 young drivers do not have claims in a particular year, and there may be a "hard core" of chronic claimants in this group. The amount of overcharge in dollar terms may well be so great that many of the "good" drivers in this group who would buy collision coverage at $200 will not at $600. Income constraints, preferences for other goods and services at that price level, resentment of perceived overcharges, and the degree of risk aversion all play a role. Pricing at the $200 rate, conversely, would increase undercharges for those under-25 drivers with expected losses greater than $600. New undercharges would be created for those with loss expectations in the $200-$600 range. To the extent that such people would buy collision coverage anyway at $600, no distortion results from the change in pricing. Inefficiency results to the extent that such persons buy collision insurance as a result of the lower price.

Undercharges and overcharges of the same dollar amount may not have mirror effects on consumption. An overcharge of say $100—reinforced by resentment and income constraints—may well affect an insurance consumer more than an equivalent undercharge. Similarly large overcharges may have disporportionately greater impacts on consumption patterns than small overcharges. If these two hypotheses are true, a refined multi-class pricing system will actually be less efficient than a one-class system. To find the answer requires a complex empirical examination. But to conclude a priori that more refined classification plans are necessarily more efficient is erroneous.

X. COMPETITION AND COLLECTIVE ACTION

As suggested above, what is good for society will not always be good for an individual insurance company acting independently. Any one company which unilaterally ceases to use classification or underwriting information which explains some measure of expected loss variance, even if small and subject to substantial error in individual cases, will suffer adverse selection in the marketplace. Similarly, any single company which seeks to modify the conduct of providers of insured goods or services, or to reduce levels of reimbursement, in an effort to contain costs will tend to lose business to insurers willing to pay providers whatever they charge. Insureds are likely to resent bills for balances remaining unpaid after insurer reimbursement, and providers may refuse to cooperate, or do business at all, with an insurer who resists full payment of their charges when other insurers do not. Finally, an insurer who seeks to cut back on unnecessary or questionable utilization of services by insureds runs the risk of losing business to less socially concerned insurers.

If, however, all insurers within a jurisdiction are required to meet rules and standards of universal application which require socially desirable actions, no single insurer is thereby disadvantaged. The need for residual market mechanisms will tend to increase in order to accommodate those insureds considered underpriced under the rules, but most property/casualty markets already exhibit the need for such arrangements. Reinsurance facilities, in which all insurers writing a line of business share equitably in the losses of the involuntary market, can provide full availability of essential insurance coverage while avoiding the surcharges and stigma typical of assigned risk plans.

What is important is that a uniform framework, applicable to all insurers, be established. Within the standard ground rules, the forces of competition would operate freely. The rules should be structured so as to prevent the adverse consequences of unfettered competition, such as uncontrolled risk selection competition and unwarranted uncertainty loadings in base rates, while preserving its benefits, primarily the impetus toward more efficient insurer operations. Development of such a framework must be undertaken by an authority with jurisdiction over all insurers in a market, the ability to establish residual market mechanisms, and a commitment to the public interest. Government alone meets these criteria.

XI. COMPETITION AND INCENTIVES

The structure of an insurance rating and classification system will generally have an impact on the level of losses covered by it. The stronger the incentives for loss prevention and retention, the lower will be the losses incurred. The structuring of an insurance system to maximize loss control and cost containment, consistent with sound coverage and reasonable administration, is an important goal of public policy. An individual insurer in a competitive market, however, has little or no interest in establishing incentives to control future losses for the market as a whole, or even for its own book of business. Rather, its primary interest will be in separating out insureds who are likely to have lower or higher-than-average losses. Classification variables such as sex, age, geographic location, or marital status create no useful incentives, as they are wholly or largely out of the control of the insured while not directly and causally related to expected losses. The use of characteristics like driving record and property management, however, creates useful incentives to modify behavior to reduce losses, both actual and reported.

In addition to creating loss-reduction incentives for insureds, it is important to establish incentives to contain inflation in prices paid to providers of insured services and replacement goods. To the extent insurance mechanisms penetrate markets, normal cost incentives break down. The marginal cost to the fully insured consumer of a good or service becomes zero as no additional payment is required of him. Thus, he has no incentive to comparison-shop in an effort to get a better deal. On the contrary, it is in his interest to buy the most expensive product, or utilize the most and best of available services, so long as any improvement in quality is perceived. At the same time, providers of insured products and services are freed from pressures from purchasers to hold down prices—prices which are directly correlated with their incomes. Unless insurers act to restrain costs and unnecessary utilization in insured markets, in lieu of normal market forces, prices and costs tend to escalate. This phenomenon is illustrated by the rapid inflation in such heavily insured sectors of the economy as hospital charges, physician fees, and automobile crash parts prices.

Individual insurers who seek in a competitive environment to contain costs run the risk of alienating both suppliers and consumers. If other more cooperative insurers will write the business at comparable prices without pressuring consumers or suppliers, they will get more of the business. This effect is more pronounced among sophisticated buyers, such as large group health insurance accounts. In the long run, an insurer which consistently contains loss costs and which bases rates on its own loss experience alone, will gain a price advantage in the marketplace. But immediate pressures of angry consumers or suppliers—if they have the alternative of taking their business elsewhere—tend to overwhelm the more remote benefits of somewhat lower rates. The problem can be especially severe with regular providers of insured services, who may refuse to deal with such a company or to accept customers insured by it.

Only if cost containment and utilization control measures are mandated to apply to all insurers equally will no single one be disadvantaged by applying such policies. As with risk selection competition, the creation of uniform rules applied equally to all insurers and established to implement important public policy objectives, is necessary to assure that competitive forces operate in the public interest. Unfettered competition alone will not only fail to bring about incentives for loss control, it will operate to thwart their realization.

Insurance is virtually unique among businesses in that its production costs are significantly affected by the prices it charges. The level of insurance claims is to some extent discretionary with insureds. Mirroring positive incentives to limit claims to the extent insureds feel "ripped off" by insurers, they may pad otherwise legitimate claims or fabricate new ones. A few extra items added to a theft claim or the repair of pre-existing damage on an auto collision claim are examples. Under widely used classification and underwriting systems, small subsets of the insured population are charged rates several times the average, despite perfect claims records in many cases. Anecdotal evidence strongly suggests that many persons in these classes take out their anger by trying to "retrieve their premiums" from the companies through claim payments. It is interesting to note, for example, that the theft claim rate for under-25 male drivers, who pay the highest auto insurance rates, is in a number of jurisdictions far higher than the average. Presumably a bona fide car thief does not know the age of the owner of the car he is stealing.

The more frequently fraud becomes a response to high rates, the higher rise the losses in high-rated classifications. Premium rates then rise to reflect the increased losses, the problem is exacerbated, and a vicious spiral ensues. Under unfettered competition the usual response of companies is to refuse to insure entire classes of business or to load the rates with extra uncertainty factors. Neither response is socially constructive. Only if standards reflecting the broad public interest are applied with the vicious cycle be broken. Once again the unique nature of the insurance product prevents competitive forces acting alone from leading to a socially desirable outcome.

XII. COMPETITION AND EXTERNALITIES

One of the preconditions for the successful operation of competition is that the costs paid by producers include all costs to society of the activity in question. To the extent that social costs diverge from private costs, and social benefits from private benefits, the allocations of resources based solely on prices reflecting private costs will not be optimal, and resource use will be inefficient. Pollution is probably the best-known example of an economic externality. When firms freely pollute air or water with byproducts of manufacturing, users of the air or water absorb the costs. If producers absorbed the costs, equilibrium prices would rise, smaller quantities of the product would be produced and consumed, and either pollution would be prevented or cleaned up, or society would be compensated by the producer for its loss in air and water quality. Only through societal intervention will externalities be internalized or otherwise corrected and the imperfections resulting from diverging social and private costs removed.

Not only will pure competition not prevent such misallocations, it will tend to exacerbate them. It is in the interest of any one producer to continue to pollute so long as it derives any benefit from doing so, if the cost is zero. Under competitive conditions companies which act to increase their out-of-pocket costs by preventing or cleaning up pollution will find themselves at a competitive disadvantage if others do not, as the polluters will achieve lower costs and the ability to charge lower prices.

In the insurance business externalities are widespread. By its very nature, insurance affects persons other than policyholders. Spouses and children depend on a breadwinner's life, disability, and health insurance. Motorists depend on other drivers' liability insurance. Consumers depend on products liability coverage. Patients expect their doctors to be covered against malpractice. And so on. Third-party effects are pervasive throughout insurance markets—the rule rather than the exception as in most product markets. Yet under a regime of unfettered compensation, such effects need not be included in the calculus of costs and benefits relied on by buyers and sellers. External rules and standards are necessary to protect the reliance interests of third persons not party to the actual purchase and sale of policies.

In some instances insureds whose activities increase loss probabilities for others do not pay for those costs. Conversely, insureds in some cases are charged for increases in hazard resulting from the actions of others. A good example of this problem is the rating of suburban drivers who commute into central cities. Automobiles are generally rated for insurance purposes on the basis of the principal place of garaging. Although small surcharges are sometimes imposed for driving to work, the location of the commuting destination is typically not considered. Thus a suburban insured who drives into a city center every workday at rush hour will pay no more than a resident of the same town who goes to another suburb or, in many cases, who does not drive to work at all. If a commuter causes an accident in the city, that accident under most statistical plans will be charged back to the town of principal garaging. But rating plans give no recognition to the impact of the congestion caused by suburban commuters on accident probabilities for urban residents. The greater the congestion, the higher the probability that city-dwellers will cause accidents. Although this incremental hazard results directly from the influx of commuters, the city residents are required to pay the resulting costs under the differentials imposed by territorial rating systems.

Under a wholly competitive regime each insurer is under pressure to charge the full expected loss costs of urban residents – or any other class – to the class regardless of who is responsible for the losses. Failure to do so would result in underwriting losses on urban business as a class. Once again, only industry-wide intervention by government can correct inefficiencies and inequities resulting from externalities.

XIII. COMPETITION AND ENVIRONMENTAL HAZARDS

An environmental hazard is exposure to loss which results from factors beyond the control of individual insureds and affecting a broad class of insureds. Examples are riot, urban blight, or crime. If a homeowner lives in an area which is vulnerable to riot, there is little that he can do individually to reduce the likelihood of such an event. Although riots are a broad social problem, a wholly competitive insurance pricing system will charge the potential victims with the entire expected losses from such a peril. To do otherwise would, for a competitive company, clearly be poor business practice, as the company would not receive sufficient premiums to cover the claims it would expect to pay. If the company were unable to project a reliable estimate of the expected losses on such properties, or if its estimate were more than the property-owner could afford, the result would be no coverage on the property. Certainty such an outcome is socially undesirable. Unable to obtain essential basic property protection, many persons would find themselves unable to own property in such areas. Values would decline, abandonments increase, and urban blight accelerate. Concern about this outcome underlies the operation of FAIR Plans, which guarantee the availability of basic property protection in approximately half the states.

Similarly, surcharges on rates charged owners of such properties burden residents of such neighborhoods – the potential victims – with the entire estimated costs of civil disorder, urban crime, and similar hazards. Doubts about the fairness of such an allocation of burdens led the Congress in 1978 to approve the Holtzman Amendment, which prohibits rates to FAIR Plan customers above those in the voluntary market, as set by the principal rating organization.[61]

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[61] 92 Stat. at 2097-98.

As passage of the Holtzman Amendment suggests, direct intervention by government is necessary to prevent the burden of environmental hazards from being concentrated on the likely victims. Complex issues of fairness are involved in the determination of what perils represent environmental hazards and who should bear the burden of their costs. But to leave insurance pricing to competition alone will ensure that the victims of many social problems will bear their costs in full, if they are able to purchase protection at all.

XIV. CONCLUSION

As the foregoing analysis indicates, competition in insurance markets takes a number of forms and has a variety of effects. Public policy in this area must address the specific ways in which these markets compete in order to produce outcomes consistent with the public interest. Potential gains in efficiency are available from increased reliance on price competition. But the fact that the industry is not structured monopolistically does not establish a case for total deregulation. The relatively low nationwide concentration ratios, moreover, do not necessarily translate into the absence of monopoly power in actual markets. Most insurance is sold within relatively narrow geographic markets, and relevant product markets are limited to coverages which are reasonably interchangeable. Thus even though 4,800 insurers sell some kind of insurance somewhere in the country, frequently only a handful sell a particular coverage in a given locality. And companies with tens of billions of dollars in assets may exert substantial market power by virtue of size alone.

The Insurance Competition Improvement Act addresses the complexities of the competitive dynamics of insurance markets. It would promote competition on the basis of price and service by effectively prohibiting either public or private regulation of basic rates for automobile and property insurance. At the same time, minimum standards to be implemented by the states would protect consumers from the consequences of excessive reliance on selection competition.

The proposed legislation would replace the current broad immunity of the insurance business from the antitrust laws with a limited safe harbor for the joint gathering and use of loss data. The bill would expressly prohibit the pooling of expense data or joint determination of trend and projection factors used in rate-making. The bill would vest the Federal Trade Commission with authority to enforce the Sherman and Clayton Acts with respect to the business of insurance, but would bar regulatory activity by the FTC in states which were in compliance with the minimum standards established by the bill.

To further promote price competition, the bill would require auto and property insurance policies to be easily readable and price information to be readily available from insurers and their agents. State insurance commissioners would be required to prepare and cause to be distributed consumer shopping guides containing specific relative price information. At the same time, commissioners would be prohibited from regulating standard base rates for auto and property insurance. Special emergency authority to regulate rates is provided, however, in instances where competition was found to be insufficient to assure that rates will not be excessive.

The bill contains a number of provisions designed to mitigate the consequences of excessive reliance on selection competition. Basic civil rights protection would be extended to the insurance industry by the bill's prohibition of discrimination on the basis of race, religion, national origin, color, and sex, *inter alia*, in the sale or rating of property and auto insurance. Access to essential coverage would be protected by the bill's limitations on insurers' freedom to refuse to insure, cancel, or non-renew objectively insurable risks. Basic due process safeguards—timely notice of and statements of reasons for refusals to provide or continue coverage, and a right to impartial review—are granted to prospective and current policyholders. The bill also protects agents and brokers from arbitrary termination of contracts and reduction of commissions on residual market business.

The bill would establish standards governing the use of classifications and territories and applicable rate differentials. Prior to using any classification or territorial rating category, the appropriate commissioner must approve its use as fair, just, reasonable, and not unfairly discriminatory. In reaching this determination, substantial weight must be given to the compatibility of the use of the category with widely held social values, the positive incentive effects its use creates for the reduction and retention of losses, the degree of causal connection between the category and propensity for loss, the degree of controllability by insureds, the accuracy of pricing which results for each individual insured from the use of grouping, and its statistical validity. The bill would establish somewhat similar standards to govern rate differentials between classes and territories. The bill would prohibit the use of allocations of general and acquisition expenses by class and territory which do not reasonably reflect actual differences in the costs of servicing different classes of insureds; it would also prohibit the use of actuarial methods of computation which systematically overcharge individuals in the highest-rated combinations of classification and territory. Primary weight must also be given to the accuracy of rating of each individual member within any classification or territorial grouping, the avoidance of large overcharges of individual insureds, and a broad distribution among insureds of the costs of environmental hazards over which insureds have little or no control. In addition to these guidelines, the bill imposes caps on territorial and group classification differentials of 2 to 1 for each. Thus the maximum rate within a state for a young urban driver with a perfect record would be $2,000 if the lowest rate for the rural adult were $500, all other factors being the same. Differentials based on merit rating, mileage driven, and make, model, age, value, or damageability of an insured vehicle are exempted from the caps. Caps of 1.5 to 1 on similar bases are applied to property insurance.

Implementation and enforcement of the bill's standards are left to existing state regulators. Federal involvement is limited to the establishment of a private right of action in federal court, but only in states which have not enacted the standards into law. There is no provision in the bill for federal regulation of insurance, even as a back-up approach.

The controversy which has been generated by this bill suggests the importance of the problems it addresses. But to a large extent the debate on the role of competition has not confronted the complexities of its actual operation in insurance markets. There is no question that many practices of state regulators of insurance have often been anti-competitive and of little benefit to consumers. Others, especially in a handful of progressive states, have been of substantial benefit. But it would be a serious mistake to sweep all regulation aside and trust solely to open competition and the antitrust laws. Although joint rate determination through industry rating bureaus or otherwise should not be permitted, the unique nature of the insurance product requires that broad standards and rules be implemented by government in order to assure that competitive forces operate in the public interest. The role of government should be judged not only on the basis of failures in the past, but on the potential for benefits in the future.

RATES FOR NEW HAMPSHIRE MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION

CLASSIFICATIONS	LIMITS IN THOUSANDS						EFFECTIVE JULY 1, 1984		
PHYSICIANS	25/75	100/300	200/600	250/500	250/750	500/1,000	500/1,500	1M/1M	1M/3M
Class I - No Surgery (other than incision of Boils, Suturing of Skin) or Obstetrical Procedures	1,145	1,569	2,071	2,181	2,212	2,573	2,636	3,044	3,311
Class II - Minor Surgery, Assisting i major surgery on own patients or Obstetrical Procedures - not major surgery, Needle Biopsy, Radiopaque dye Injections, Myelography ...	2,062	2,824	3,728	3,925	3,982	4,631	4,744	5,479	5,959
SURGEONS Class III - General Practitioners assisting in major surgery on other than own patients, including Catheterization (Not including Cardiac Surgery), Ophthalmologists, E/R Physicans - no major surgery, Acupuncture, Radiation & Shock Therapy, Arteriography	3,507	4,804	6,581	6,678	7,014	7,879	8,071	9,416	10,377
SPECIALISTS Class IV - Urologists	4,613	6,407	8,778	8,906	9,354	10,507	10,764	12,558	13,839
Class V - Surgery: Laryngology, Cardiac, General, Othrhinology, E/R w/Major Surgery, Otology, Otorhinolaryngology, Rhinology, Abdominal, Anesthesiology	5,766	8,008	10,971	11,131	11,692	13,133	13,453	15,696	17,297
Class VI - Surgery: OBS, GYN, Plastic, Hand, Head & Neck	6,918	9,609	13,164	13,357	14,029	15,759	16,143	18,834	20,755
Class VII - Surgery: Thoracic, Vascular, Orthopedic, Neuro, Cardiovascular Disease	9,225	12,813	17,554	17,810	18,707	21,013	21,526	25,113	27,670

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 319            91             18             1              0              1              1

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 170            144            66             33             12             2              4
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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY AN    AnesThesiology

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%           11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 4              11               3               1               0               0               0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY AN

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%           11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 2               6               7               3               1               0               0
```

NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire: Please state in what way you may have had to alter your field or practice in order to be able to pay your medical liability premium. Has there been any restriction on what you have been able to do in the past? If so, name specific procedures or areas of surgery.

Anesthesia

In early 1984, went on part-time schedule. Because of new government regulations had to change billing system...this coupled with increased malpractice premiums has been disastrous. May have to retire completely if further increase in premium - earlier than planned.

Reduced annual salary (4 MDs 4 CRNAs) to pay premiums; have not been able to fully fund retirement plans and had to file for extension on IRS.

I had hoped to slow down my practice volume as I approached retirement. Because of this confiscatory insurance cost, I will have to work full tilt and then abruptly quite, causing my patients a loss of my expertise and causing me an inadequately funded early retirement.

Over the past few years we have had to make small increases in our fees to attempt to pay for the increase in ML premiums. There is no way that we can change our practice to fall into a lower medical liability category.

raise equipment $5,000/year, raise lab test $60/patient...both only for legal reasons.

Difficult to recruit new associates when cost of malpractice is so high. We are forced to take on every in our hospital - good risk and bad alike - we cannot refuse care to anyone for any reason - we are at the mercy of the JUA.

No alterations yet. Fortunately I'm close to retiring and the premiums just help me to make up my mind to retire sooner.

Less income. Inability to work part-time or slow down....the premium is too high to allow slow-down.

Increase fees. Increase workload.

Raise prices. Open a line of credit.

No change in current practice. I am however planning to seek employment outside clinical medicine. Other alternatives are VA employment or transfer to a state where income, relative to insurance costs, is higher. Another possibility, which I am seriously considering, is early retirement.

In the past some of our nurse anesthetists performed regional anesthesia, because of malpractice problems, we have restricted this although that makes no differences in our premiums. In order to best serve all patients, we have not restricted our practice by type of anesthesia (except as above) or procedure. Therefore, unfortunately, we have had to cover increased premiums by passing on the casts to our patients in higher fees. One of the factors influencing hiring more physicians vs. nurse anesthetist is the difference in malpractice premiums (as well as other salary differentials), it is economically sounder to hire nurse anesthetists rather than provide physician anesthesiologists.

Work harder.

Am serving small hospital. Income generated is unpredictable. May have to start assisting to generate extra income. Malpractice charges may force doctors from small hospitals and patients will ultimately lose out.

I do not practice every day but about 40 hours/week. If the insurance goes any higher, I will have to stop.

No changes or alterations were necessary.

Lower income from practice and also makes it impossible to do anything but full-time practice.

Emergency Medicine

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY EM

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 7              4               0               0               0               1.              0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY EM

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?  (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 3              6               2               0               0               0               1
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NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire

Emergency Medicine

Overall fees have been raised in the ER to meet the premium. We probably also charge employees who are seen in the ER for care more often than before the increases.

None at present. Would not resume obstetrics if ever returned to family practice. Approximately 30% of x-rays and laboratory I would consider unnecessary in the strict medical sense, but are done because of potential medical liability or because the patient will be a litigant in some other way.

No longer in private family practice - semi-retired - still attempting to prevent malpractice situations by providing high quality care but I am concluding this is an inappropriate appraoch to preventing malpractice claims.

It is difficult to attract physicians from other regions when the malpractice overhead so erodes our net income.

Grin and bear it. Have not yet had to give up procedures re. malpractice costs. It does, however, force certain defensive practice habits upon me, i.e. no matter what the cost I musn't ever be wrong. The malpractice climate infuses the physician/patient relationship with a subtle adversarial poison.

I have not changed the field or manner of practice. I have had to curtail my standard of living to compensate for loss of spendable income. I am 64 years of age. Because of impediments which stand in the way of my medical practice, not the least of which is malpractice premiums, I plan to retire next year, instead of waiting until age 70.

Increase charges.

Stopped giving I.V. analgesia for setting fractures - stopped setting most fractures.

Having done a residency in general surgery I was actively assisting in major cases. However, the new premium rates would add $7,000 in order for me to assist on "other than my own patients" and would raise my rates to almost 20% of my gross income. I think this is ridiculous considering the fees you do receive for assisting. As a result I've had to drop my surgical assisting privileges. In small hospitals this creates a problem since assistants are not readily available especially for difficult major cases.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY FP/GP

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%           11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 73              8               1               0               0               0               0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY FP/GP

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%           11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 41              27              9               4               0               0               1
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Family/General Practice

NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire:

Family Practice/General Practice

Increase in fees for patient visits, order more lab tests for defensive medicine, ask for more consultations, raising cost to patient or third party.

Have eliminated procedures (eg TOP's) because cost for malpractice is more than income for the procedure, certainly has contributed to our need to raise office charges; has increased caution and possibly affected the ordering of blood/x-ray tests.

I have already altered my medical practice. I was a general surgeon but because of the high premiums and the decrease in surgery, I am now a general practitioner.

I have eliminated all minor surgical problems and no longer assist in surgery on my patients.

Present practice started Sept. 1983. I've stayed iwthin the specific bounds delineated per contract with carrier and referred what lays outside those bounds on to other doctors.

I have ceased to do any surgical assists because the increased premiums are not warranted by the income I was generating.

Not particularly. We are probably very under-covered with only 100,000/300,000. God help us if we get sued. The above figures are averaged for the two family physicians (who are married to each other) who share the practice.

Restricted liver biopsies. Increase in fees was necessary by 23% over 3 years.

Give up OBS (premiums were 2-3 times more).

Do not assist on surgery on patients other than our own. No ED work.

I don't do things that I feel are risky - this includes OB, being present at school sporting events, assist in surgery on other than my own patients.

We may have to discontinue doing obstetrics in the future if malpractice liability increases for doing obstetrics. Our hospital is served only by FPs doing OBS so this might have a drastic effect on OBS at the hospital.

No minor surgery apart from suture lacerations in order to keep in Class I; no circumcisions; no reduction of fractures or dislocations.

Discontinuing assisting at surgery.

Changed classification: no longer able to do surgical assists, vasectomys, or set fractures.

Eliminate emergency room.

I have discontinued assisting in surgical operations on my own patients. I do more tests (blood & x-ray) and requst more follow-up appointments.

FP/GP-2

I have given up surgical assisting both for my own patients and those of other physicians because the amount of money this activity brought in did not equal the amount of additional premium I would have had to pay.

See higher number of patients; certainly practice defensive medicine ordering more lab tests and x-ray procedures, stop doing OBS and any surgical assisting.

Increase fees.

Have had to stop assisting in surgery on patients other than our own; practice defensive medicine, raised our fees.

Have dropped epidural anesthetics for delivery hence reducing premium by more than half.

None, except as relating to overall decision not to practice obstetrics.

Stopped obstetrics, stopped assisting at surgery on any patients, continue to practice defensive medicine - even more than previously, raised fees to cover malpractice rates.

Gave up all surgery in the office and hospital and also surgical assists in order to cut down premiums.

Have eliminated all procedures which would prevent level I classification. Gradually, we have given up surgical assisting, emergency room work, circumcisions. We accept new patients only when screened by my staff or recommended by an established patient. We rely less on 25 years of practice experience and refer more.

Do no assist in surgery on patients other than my own. Do not work in the ER.

We are no longer assisting in surgery on our own patients.

Increase number of patients seen daily.

Stopped doing OBS.

Next year I will be dropping coverage to assist on major surgery on other than my own patients. I will also not be able to do part-time ER work starting in June. Finally, I will not be able to put in swan-ganz catheters or do tubal ligations next year because I will be dropping down to a lower class because of cost.

Have only been in practice in NH for a little over a year. I am currently practicing the full extent of my specialty, including routine obstetrics, D&Cs, and ER coverage. However, if premiums continue to rise I will have to make some choices.

I am most concerned that liability premiums for simple, uncomplicated obstetrics not be boosted to the same level as operative OB/GYN. This would "price" the FP out of competition because of the relatively low numbers of patients involved. I do not believe normal OB to be a high-risk situation, and cannot accept an increase in premium for the adequately trained FP to add OB to his practice.

I have reduced practice in taking early retirement, anticipating doing (1) house calls, (2) insurance exams, (3) locum tenens, (4) part-time ER. Insurance requirements prohibited (4) part-time ER because an additional premium exceeding part-time remuneration was to be rquired in spite of coverage provided by the ER.

None, it just raises prices.

Had to discontinue doing epidural anesthesia for labor patients (was adding approx. $6,000 to premium 1 year ago) and now must use a much less safe method - I.M. demerol.

I have cancelled all surgical assisting my own/other doctors patients; obstetrics; fracture treatment.

Have had to stop doing major surgical procedures and plan to stop doing assistants work on patients other than my own.

Considering dropping obstetrics.

Not able to assist at surgery in other than my own patients.

Limit amount of welfare payments. Did not become or accept assignment on all medical services. As many family members as possible employed here.

Dropped assisting at surgery and ER work.

I assist with surgery on my patients, which I feel is a benefit to the patient and myself. It now costs me an additional $2600/year to do this so I barely cover the cost and may have to eliminate this service to my patients.

I have been considering giving up T&As and assisting on other than my own patients.

Work harder and borrow money.

Will not do dilation and currettage for completion of miscarriage and assist surgery/ER only on own patients.

Serious consideration has been given to stop doing OB because of the increased malpractice rates spread over small number of cases in this rural area. Also assisting in surgery. Each of these will be done by other MDs who would charge appreciably more for the same service.

No longer work in ER. Strongly considered dropping liver bx/swan-ganz placement due to higher premium of Class II vs Class I.

Do not apply casts any more. Do not cover ER any more.

I have stopped doing OB work; assistance in surgery on all patients including mine; emergency medicine, selected surgical procedures altogether.

I have stopped all surgical and orthopaedic fracture care procedures. I have stopped assisting at surgery on my own patients which I feel renders less than the best care in the latter instance and increases cost to my patient in the former instance.

I do not do obstetrics or ER because of premium costs. Because I am in the lowest premium category I cannot assist in surgery on my own patients.

No longer do surgery - only assist on my own patients. No longer cast simple no displaced fractures.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY GS

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 22             28             6              0              0              0              0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY GS

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 2              19             20             10             5              0              0
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General, Thoracic Vascular,
Plastic & Neurosurgery

NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire:

General, Plastic, Neurosurgery

Have not had to alter practice at this time although does prohibit potentially taking on associate.

Have carefully screened patients for elective surgery - no procedures have been deleted. Rapid rise in costs have essentially meant reciprocal loss in personal income.

I have hesitated increasing my fees because of the weakness of the economy and there has been no increase this year despite a jump of 30% in my premiums. I did increase my fees that I charge lawyers.

Continued escalation of fees for service. No restrictions so far.

Increase fees that I can't collect but can "write-off." Reduce expenses. Do more assisting of other surgeons.

I have had to totally give up the peripheral vascular and thoracic part of my practice - very unwillingly - to continue would have cost an additional $6000+.

So far I have not altered my practice but I may do so over the next few years.

Have stopped doing surgical procedures that increase the risk and thus the premium, i.e. vascular and thoracic.

Presently considering restricting my practice to purely general surgery. Also considering relocating to an area where survival as general surgeron with vascular and trauma is more likely. My practice and consequant medical care for a rural community is in severe jeopardy.

Raise fees 8-10%, eliminate surgery where increased cost of insurance does not cover returns from surgery (e.g. some hand surgery, some head and neck surgery, no vascular or thoracic surgery), take loans to cover malpractice premiums.

Provide less reduced rate or free care. Pursue delinquent accounts more vigorously.

No restrictions as yet, just increase in fees.

Increase charges to patients. Practicing only "my specialty."

Drastic increase in charges.

Give up major surgery. I already gave up reconstructive surgery.

No vascular or thoracic surgery.

None so far but if it goes higher I will have to alter practice.

I have had to do more ER coverage (working as an ER MD) as there has not been sufficient general surgical work. I now work 7-8 days/month in the ER (about 40 hours/week).

I have gone to fewer out of town meetings becuase of cost (and loss of work while away). I have deleted elective vascular & change surgery to keep cost of insurance down. This problem and the constant inane intrusions into medical practice by the state PRO and other government agencies would make me think twice about going into medicine again.

Stopped doing peripheral vascular surgery - are prohibitively expensive.

Have obtained medical liability through Massachusetts because the cost is too high in NH. (from Salem)

I work harder and have less to show for it. I practice defensive medicine and tend to over order studies to protect myself from possible suit.

The means in which I have decreased my exposure is that cases of moderate difficulty with questionable good outcome, I have referred to medical centers in Boston. I feel that I could have handled them adequately but with the potential of less than satisfactory results I feel it would increase my exposure. I realize that by sending the patient to these medical centers the cost of care delivered to them in Boston is much higher than it would be here in NH without any real improvement in capability of delivering it. Specifically, peripheral vascular disease cases where run-off is marginal and chance of success is also low would, be a type that would be send to Boston. The most significant way in which it has altered my practice is the fact that I am leaving NH because after all fixed expenses are covered what is left over for my own personal use is insignificant compared to the time and effort I put into the profession to generate the money to cover these outrageious premiums.

I have discontinued vascular and thoracic surgery in order to reduce my premium from $25,000 to $18,000. I avoid ER referrals whenever possible.

None yet - I am considering dropping chest and vasc. surgery as the extra expense is not worthwhile.

Increase fees for all patients to defray cost of vascular and thoracic surgery extra premium. Stop any "free" or complimentary care or consultation including second opinion program. Refuse all but emergency "welfare" or non-paying patients.

Limited ability to purchase new equipment. Restricted vascular and thoracic surgery.

I discontinued doing GYN surgery or fracture work because of the high additional premium. I had been doing this type of work following my surgical training for approximately 28 years before the above described discontinuation.

Limiting practice to area of lower premium and leaving practice sooner.

Increased fees to help pay for increase in malpractice premium. If increases continue and I am not allowed to increase fees to cover (i.e. Medicare freeze) would be forced to stop gyn, plastic, hand, head and neck surgery.

Eliminate thoracic and hand surgery. Get more consults and 2nd opinion than are medically necessary. Increase number of tests ordered to CYA.

have discontinued doing vascular and thoracic surgery. I am working longer hours and king fewer vacations.

almost have had to give up some types of surgery due to pressures-to take care of the eds of patients in this areas we have not (i.e. vascular and chest).

have increased my surgical fees to compensate the increased premiums. There have en no restrictions or actual change in practice patterns.

have dropped all gyn, orthopaedic, thoracic and peripheral vascular surgery and limited practice to abdominal and endocrine areas.

thoracic/vascular surgery; no hand, tendon repairs; the increase premium $ has resulted increased fees - not fair to the public but there's no alternative. The "system" won't lerate these increases forever.

es have had to be increased enormously to pay premium of $31,000/surgeon.

ise fees to the maximum extent permissable under third party payments.

Internal Medicine

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY IM

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 72             3              1              0              0              0              0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY IM

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%          11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 50             21             5              0              0              0              0
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NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire:

Internal Medicine

I changed coverage to 500,000/1,500,000. Used to carry 1,000,000/3,000,000.

None, except less income.

Less vacation. No raise in 7 years.

I no longer assist at surgery on my own patients. I've raised my charges enough to cover the increased premium.

I am a fully board certified cardiologist yet I have stopped implanting temporary pacers and pulmonary-artery catheters because I was losing nearly $3000 annually because of the additional coverage needed. Also, I try to avoid defensive medicine and am pressured to obtain some tests because of the malpractice atmosphere.

Increase cost to patients.

* I gave up my ER duties (2-3 times a month) because of the increase in liability premiums in that area of medicine. Additionally, I would also make the observation that I order many more tests and request many more consultations than my judgment would indicate are turly necessary in order to rule out diagnoses of a very low order of probability.
truly

I gave up ER work.

I have had to stop taking ER call (a problem in our small rural hospital) because the cost of the additional coverage made it impossible to work on an infrequent basis (to help out the others doing it). It is hard to define how much "defensive medicine" I practice - not much in our area.

Have restricted all invasive procedures and practice in more conservative medico-legal conscious manner. Have essentially stopped all pulmonary practice.

Price increases to patients.

No essential change in practice style, however, the tendancy exists to increase the numbers of procedures to offset increase practice overhead. I do not do a complete permanent pacemaker implant but not for liability reasons.

Raise fees.

Have not restricted myself although in order to remain in my present classification I must limit myself to a certain number of balloon tipped hemodynamic catheters per year. So far not a problem but if volume increases dictate need for more procedures then I will have to decide whether or not to accept the increase in premium or limit the numbers accordingly. Of note: When I began placing swan ganz catheters, the increase in liability premium exceeded the gross income from the procedure. Presently, I break about even!!

No kidney biopsy. No surgery of any kind. No invasive procedures.

IM - 2

In the past I have assisted surgeons in the care of patients not defined as my own. Becasue of the increased premiums I have stopped providing this service.

I no longer assist in the OR on my own patients - a popular and enjoyable past practice which would increase my malpractice insurance costs by far more than it would yield in income.

Will not participate as assistant to surgeon on cases other than my own.

Gave up doing any liver biopsies. I had done these for the past 15 years and never had a complication but could not afford the extra malpractice cost.

Reduction in invasive cardiovascular procedures.

Sometimes practice "defensive medicine."

I cannot afford to do certain procedures that I have been trained to do because the jump in class would mean an increase of medical malpractice of $7,000+.

In order to keep my liability down to Class I I have stopped doing the following procedures that I am well qualified to do: Needle biopsies of liver, pleura and bone. I am also the only one within a 35-minute radius who knows how to insert emergency pacemakers and swan ganz catheters and I discourage their use in order to keep my premium down.

None, but my partner has had to stop working in the ER one night a week becuase of a $6092 surcharge.

As liability costs increase this is passed on to my patients as higher cahrges.

Mine is a new practice and I had to borrow the initial premium which represented 25% of all the money I borrowed to start my practice. I practice critical care in a rural area - for my insurance class the number of procedures I do does not pay the premium differential (difference between Class II and Class III). In other words I perform swan-ganz catheterization and temporary pacemaker implantation for free. Yet, these are very often procedures essential to a patient's very survival.

Raise rates.

Stopped assisting on surgical cases.

Stopped ER work and surgery assisting.

Greater use of EKG, x-ray and laboratory services. Greater use of hospital - for instance patients with chest pain are admitted to the intensive care unit with lower suspicion of myocardial ischmeia than previously. Certain procedures (for instance, insertion of Swan Ganz catheters) not done because doing them would put me in a higher malpractice insurance premium category. Certain higher risk procedures (for instance, pericardiocentesis) no longer done although qualified to do them and previously done without mishap. More frequent referral of seriously ill patients to othe rfacilities.

Charges have risen and I practice more defensive medicine because of concerns about lawsuits.

Borrow money.

I have stopped ER work because of high malpractice premium. I do not do pleural biopsy.

Increase fees. Stop ER work. No procedures directly outside my immediate field of practice.

No longer do invasive procedures such as liver biopsy, bone marrow biopsy - call a consultant to do this.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY NEW

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 5              0               0               0               0               0               0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY NEW

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 3              2               0               0               0               0               0
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Neurology

NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire

Neurology

Introduction of chemotherapeutic agents into CSF - procedure essentially doubles the premium.

Restricted the number of Medicaid and Worker's Comp. cases seen per month; borrowed money to pay bills on time.

My malpractice rate was cut 2/3rds in switch from Aetna to Penn Casualty coverage.

I no longer do a large number of contrast procedures - and am considering discontinuing arteriography.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OBG          Ob-Gyn

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%         11-20%        21-30%        31-40%        41-50%         51-60%         61-100%
 18             9             4             0             0              0              1
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OBG

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%         11-20%        21-30%        31-40%        41-50%         51-60%         61-100%
 4             11             7             7             1              1              1
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NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire

Obstetrics and Gynecology

Have increased fees in direct proportion to increased insurance cost. Also have probably increased testing procedures to decrease litigation risk. If premium in obstetrics continues to increase, would probably consider discontinuing OB services.

Until Feb. '85 my annual premium has been just less than $3000 (thru ACOG), from that date it will be approximately $18-20,000. I have made no restrictions. I am currently exploring opportunities with pharmaceutical companies and shall have to retire from practice.

I seem to ask for 2nd opinions on more frequent basis. Do more expensive diagnostic procedures. Seem to refer patients for even slightly complicated conditions to tertiary centers. In short, my income is going down rapidly and the expenses growing daily. How anybody can contain costs is beyond me. I do not have large savings to pay the insurance carrier - so patients will have to bear the brunt - so cost containment and fee freeze is a joke of the year.

Malpractice insurance increased from $7,000 to $17,000 - only alleviation is to increase charge of course.

Cost probably passed on to patient.

The liability situation has made it necessary to pass costs along to the patient. There have been no changes in our practice because of this.

May have to give up the practice of OBG.

I have become more cost conscious; fee increases required to offset increases in malpractice, I have not stopped any part of practice due to same.

Raise fees, but can't increase them to level needed to cover increased premiums. Worry and fret. Search for alternative career.

Rates have increased 300+% in one year with ACOG insurance plan. Plan for future: increase fees, give up OBS or both, suffer along.

We have recently had a major increase in premium which made a significant fee increase necessary.

My malpractice went from $2500 with ACOG to $20,000/year. With this tremendous increase I had to raise fees.

Joined a multispecialty group. No restrictions on actual practice.

No restrictions, just more stress.

No changes yet. Just very cautious. Have considered a career change.

Increase fees to pay the premium. Practice defensively and order more tests than necessary thus increasing costs.

Increase diagnostic tests; increase fees, charge for previously uncharged procedures; limit Medicaid.

Increase fees greater than would have; practice defensively including referring certain high risk obstetrical patients not from medical necessity but primarily to avoid liability.

Raise fees 20% in the pst 12 months to compensate for over a 500% increase in medical liability premiums in one year. No restrictions in the past, but I now refer more complicated or high risk patients.

Have had to raise fees.

I have had to increase fees dramatically. I still perform all procedures that I was trained to do. I am seriously considering discontinuing the obstetric practice. I no longer enjoy this specialty where a less than good result invariably results in a request for patient records and in many instances valuable time spent with lawyers instead of time spent caring for the public.

Drop IUDs, saddle blocks, obstetrics; more ultrasounds, x-rays and lab work; more consultations with other physicians.

I was doing all right until 9/6/84 when I received a letter from the ACOG carrier stating that my annual premium for malpractice insurance was being increased from the former $2875 to $14,430, a 500% increase. I was told that the increase was made necessary by the acturial situation of the OBG specialists in NH "a few old cases have been filed recently and we found our premiums were far too low," is what I was told by an agent. I have just turned 77 and my practice now is very small but I stopped practicing obstetrics as of 10/31/84. I can get insurance to cover my practice of gynecology, female urology, and female infertility and endocrinology now for $10,700 a year. I still have some loyal old patients who want to come in to see me and I have a few major gyn operations to do, maybe after the Holidays. I thought I'd give it a try for another quarter, to see if I can "break even," when I compare my practice expense with my gross income. As long as there is any reasonable net income from practice, I'll probably continue as long as the patients come in. I've been informed that if I do no surgery or OB at all and just do general office practice, my annual premium will be about $3900.

I believe some of the other physicians doing obstetrics and filling a valuable local need where they practice, but who delivery only 20 or 30 babies a year, will probably balk at the nearly $15,000 annual premium and quit obstetrics. This will mean that the women of NH may have to travel many miles to the larger towns & hospitals to get prenatal and hospital obstetrical care, which will be a real hardship on them.

A 52-year-old OBG in the Detriot area, who I taught as a medical student when I was Prof. & Chairman of the Dept. of OBG at Wayne State University School of Medicine (where I taught for 24 years & retired at age 65 in Dec. 1972, & came here to live & be a "country doctor") who is well trained, a diplomate of the American Board of OBG & recertified recently, was coming here to practice in Wolfeboro & take over what's left of my practice, but when he learned of the 500% increase in the premium he backed off & is staying in the Detriot area. He would have been a real addition to Carroll County medicine and a help to women here. I'm really disappointed. Whatever happened to our JUA that we got into such a hole?

Ophthalmology

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OPH

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%           11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 21              2               0               0               0               0               0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OPH

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%           11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 12              11              0               0               0               0               0
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NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire

Ophthalmology

Modest fee increases are the only way to compensate for rising costs of malpractice coverage.

I've had to increase fees and limit Medicaid work.

One year ago fees were raised to keep up with the escalating premiums. We have not restricted our surgery as yet.

Increases in malpractice premium are reflected in increased fees - with the present voluntary freeze on fee increases (including Medicare's less voluntary measures) I do not know what I will do if malpractice premiums rise again.

As a result of the rising cost of liability insurance, I am unable to purchase the equipment needed to keep up to date in my field. Ophthalmology has a high level of overhead as it is.

Defensive medicine. Expensive tests only to cover the possibility of alleged malpractice rather than clinical acumen of most likely causes and Rx's - e.g. headaches.

Have already stopped major surgery and am seriously considering early reitrement - malpractice insurance is not entire reason but certainly plays a good part. It is not possible to "slow-down" practice, economically. Last medical liability premium $9005.

To reduce my premium I have eliminated part of the surgery I am trained to do because it would cost too much.

I try to charge more to make up the lost income. No change in my practice, however.

Raise my fees to cover the cost. Ophthalmology is being "ripped off" in NH. I am paying about $10,000 as Category III or $1,000,000/$3,000,000. The same coverage is $4,400 in California. Even New York and Massachusetts is less than NH.

The cost has affected me in two ways. (1) I am now unable to purchase some expensive forms of therapy, such as a laser. It also makes me more cautious than I probably should be. It also is a major problem to consider paying the higher malpractice premium in one lump sum and I find it unpalatable to have to pay a finance charge if it is to be paid on installment basis. Another payment schedule would increase the ratios listed in #2 and #3 above by a few percentage points. I will also be obtaining a list of what procedures I could eliminate to decrease my malpractice risk classification. A rural setting as the only ophthalmologist and it may affect what procedures I would offer or decline to give my patients.

Stopped intraocular surgery about three years ago.

Fewer or less frequent capital improvements equipment purchases; understaffing; there is a tendency to consider the remmuerative aspects of practice as essential for the payment of escalating premiums. Pursuing delinquent accounts much more aggressively. Much more difficult to offer free services to charity cases - when one realizes that they can sue just as effectively as anyone else. No restrictions, in fact, trying to enhance surgical repertoire to help out.

Give up all but one office telephone. Reduce office overhead by closing office completely one day a week. Reduce donations drastically. Cut back attendance at distance medical meetings. I probably will have to cut out retinal surgery or corneal transplants (which I have done for years) because of the excessively high premiums involved.

Orthopaedic Surgery

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY ORS

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%         11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 19            17              3              0              0              0              0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY ORS

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%         11-20%         21-30%         31-40%         41-50%         51-60%         61-100%
 1             13             13              6              4              1              1
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NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire:

Orthopaedic Surgery

Have had to increase fees - practice unchanged.

I may have to stop doing surgery completly, eventually retire.

Looking at alternative states to move my practice to.

No restrictions - increase in charges have been necessary.

Work harder to increase volume instead of having an associate to share in the practice.

No change in practice but taking much less salary.

I came to NH to practice part-time and pursue other interests such as forestry, land management, and music. I have had to practice essentially full time and limit my other interests because of medical liability premiums.

Fee increases; doing more high pay legal/disability work - less patient care; have stopped doing some high risk surgery (eg. spinal cases); have stopped treating or refer patients to Boston who present with hostility or emotional problems or where needed surgery has high risk of complications or uncertain outcome.

No alternation yet but more of an increase would produce some.

We raised our rates.

My income decreased. I am not able to do anything yet but I am thinking to stop doing major orthopaedic procedure.

Increased fees, no change in procedures performed, increased number x-rays - defensive medicine; do not perform spinal surgery.

Work harder, raise fees on office and surgery, stop participating in BC/BS.

Have had to raise office fees specifically to try and offset rapidly rising malpractice premiums.

Must raise prices to pay for it.

At what point should be the apogee of my career (note that to be a relative apogee) having to consider to D/C surgery. It does seem to be a significant loss of community resources if NH becomes a state that does not do orthopaedic surgery.

All surgical fees raised.

I do not do risky surgery or tak on cases where chances of success are not quite high. (eg revision total hip surgery; "re-do" back surgery). I refer cases that I don't do a lot (even though I feel I could do a good job (eg total knees, scoliosis) because if a complication occurred the 1st thing a lawyer would ask me is "how many of these have you done?"

I have to work harder. There's no way to reduce practice - it's either straight out or nothing.

Have given up major surgery and am doing primarily office work.

Work more days per year; charge higher fees; see more patients per day; hire physician assistants rather than physicians to handle the increased patient load.

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, JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

  ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OTOL
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Otolaryngology

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  ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
  0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
   12              2               0               0               0               0                0
  ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OTOL

  ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
  0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
   1               9               2               1               1               0                0
```

NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire

Otolaryngology

Have raised fees. No practice restrictions incurred.

Plan to eliminate ENT surgery in 1986.

For the first time in my medical practice I must ask the insurance status of ER patients and accident victims because all of my malpractice communication has hinged on uninsured accident or trauma victims seeking sources of financial gain. Although I still treat these people, the number of x-rays, CT scans, and laboratory tests have increased by a significant amount, as have additional medical consultations and clearances for anesthesia and surgery. My elective patient practices including pre-operative evaluations, laboratory studies, and patient counseling have not changed, however, surgical fees have increased to cover the added cost of malpractice insurance. My use of medical consultants for cardiac, pulmonary and genitourinary systems clearance has increased dramatically for those patients of which I was not 100% sure that a problem did not exist. These consultants have been requested out of the need to protect myself from "failure to diagnose liability suits."

I take ample care to practice defensively and refer high risk cases to avoid litigation.

I have increased my rates with each increase in malpractice. As yet, I have not restricted my surgery.

I order more blood chem, x-rays, Catscan, etc., more consultations, more hospitalization; stop doing rhinoplasty or any plastic surgical procedures. I encourage patients to go for second opinion to Boton or wherever they want to go.

No restrictions in practice. Have raised fees to attempt to maintain high level of medical care in order to pay these ridiculously large malpractice premiums.

Will probably stop all surgery in near future.

I x-ray everything now even when they may not be helpful (broken noses, sinus disease).

Pediatrics

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY PED

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 17              2               0               0               0               0               0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY PED

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 15              3               0               1               0               0               0
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NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire

Radiology

Raised charges.

Fees have obviously been raised to help defray this cost.

Much more selective in cerebral angiography and inverventional procedures. I have refused to read films taken by other offices as "curbstone consult." Fees have been increased.

None, but I contemplate withdrawing from interventional radiology.

No longer practice interventional radiology (e.g. angiography); have reduced level of liability coverage and changed classification group.

It has prevented me from venturing into other subspecialties such as interventional radiology.

No restrictions, just added stress.

I have raised my fees to pay premiums; I wish to retire as soon as possible; at least 50% of the examinations I do are not medically indicated - they are done because of the threst of suite, this increases medical cost of radiation exposure; good, caring physicians are being driven from medicine and the practice of good medical care; I categorize the legal profession as despicable.

Will have to increase fees to pass the increased premiums on to patient charges.

Because of the constant threat of a "malpractice" liability suit I find that I can almost never be entirely certain of anything that I need more views, more examinations, other imaging modalities, more follow-up recommendations, all for fear of missing anything. I'm certainly aware of the other aspect of diagnostic radiology - fiz the clinician's need to order many many imaging exams where in past one might have sufficed.

Psychiatry

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY PSY

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 14              0               0               0               0               0               0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY PSY

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?   (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 14              0               0               0               0               0               0
```

NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire

Psychiatry

I have not altered my practice in any way - I probably have a bit lower income than my peers and will need to increase fees a bit sooner than I would like.

I practice more "defensively," ordering more tests which clinically I suspect strongly will be negative but which must be done to cover myself legally. This obviously raises the cost of care to the patient. I also see patients more frequently, advise less by telephone. Clinically I could practice more efficiently, both for the patient and myself, if it were not for the increasingly threatening malpractice situation.

No longer elect ECT coverage which I wasn't performing anyway.

Very minimal change besides cutting down overhead and minor increase in fees.

Just beginning a practice here in NH has been made difficult because the cash flow problem is exacerbated by the large amount I had to pay in malpractice. I opted for a lower coverage and certainly considered either not opening a practice now (even though needed here) or going without coverage.

I choose not to explore ECT as that would require an increase by 100-200% present liability expenses. So far in psychiatry (with special dispensation from State Insurance Commissioner) prices are reasonable from APA carrier.

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JSS FREQUENCY ANALYSIS FOR NH MEDICAL SOCIETY

ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OTHER     Urology

ANALYZE QUESTION # 2, MEDICAL LIABILITY % OF GROSS? (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 20             2               0               0               0               0               0
ON QUESTION # 1, FIELD OF PRACTICE? (RESPOND A-O), SELECT ONLY OTHER

ANALYZE QUESTION # 3, MEDICAL LIABILITY % OF NET?  (RESPOND 1-7)
0-10%          11-20%          21-30%          31-40%          41-50%          51-60%          61-100%
 12             8               1               1               0               0               0
```

NEW HAMPSHIRE MEDICAL SOCIETY
Four Park Street, Concord, N.H. 03301
603/224-1909

Responses to Question #4 on Medical Liability Questionnaire

Other

Not yet, but if it continues to rise, may have to stop practice or drop insurance coverage
(hypnosis)

Increased fees which my patients have not blamed me for. They understand the malpractice insurance problem, and the "ambulance chasing" by lawyers (who are getting a bad name in the community). (Urology)

High risk surgical procedures are not provided. Minor skin surgery is still performed. Patients are more often referred for a second opinion even though this does not appear necessary. (Dermatology)

I had to increase my office hours to 14 hours a day (at least two days a week) in order to be available to working patients. I had to increase my fees. Just for the acupuncture procedure done only by me, the rates for my insurance doubled, although the acupuncture is not a surgical procedure. It is well known that any MD can insert a needle in almost any part of the human body and inject solutions or medicants through that needle. For this procedure the liability premium is not increased. On the other hand, with the acupuncture procedure consisting of just inserting needles without injecting anything, the liability premium is almost double. It is a paradox. (acupuncture)

It has been necessary to increase fees. No restriction in practice. (Urology)

No change in practice. Am voluntarily slowing to part-time, no relation to insurance fees. However, will shotrly have to quit completely because of decreasing income without compensatory insurance adjustments. (Pathology)

Raised fees. (Urology)

Have considered moving practice to Maine where premiums are much lower. (Urology)

Avoidance of procedures that would be considered cosmetic surgery and thus avoid the premium that would be charged if I did such. (Dermatology)

There is no doubt that the increase in medical malpractice cases has changed the way I practice. More specifically, there are some "cosmetic" surgical procedures that I would no longer consider doing, and thus, would be more likely to refer the patient to someone else who perhaps would be more willing to take a chance on being sued. I also find that I order more laboratory studies, many of which might not be absolutely necessary to cover myself. Finally, I find that I am more included to take a biopsy of a lesion rather than treating it on the initial visit, thus, allowing the patient the opportunity of expressing their desire to be treated elsewhere once they find the nature of the problem. (Dermatology)

Have had to raise our fees. Feel the need to over-examine and over-test. (Urology)

Senator **Kennedy**. The committee stands adjourned.

[Whereupon, at 4 p.m., the committee was adjourned.]

FEDERAL INCENTIVES FOR STATE HEALTH CARE PROFESSIONAL LIABILITY REFORM ACT OF 1985

THURSDAY, SEPTEMBER 11, 1986

U.S. Senate,
Committee on Labor and Human Resources,
Washington, DC.

The committee met, pursuant to notice, at 11:07 a.m., in room SD-430, Dirksen Senate Office Building, Senator Orrin Hatch (chairman of the committee) presiding.

Present: Senators Hatch, Nickles, Grassley, and Kerry.

Also present: Congressman Robert J. Mrazek.

OPENING STATEMENT OF SENATOR HATCH

The Chairman. We are happy to welcome all of you out here today to our third hearing on the medical malpractice insurance crisis.

Up to now, the debate on this issue involved identifying victims and culprits. But our first two hearings have established that we are all victims.

Today we will meet Mary Sacco, the 1982 poster child for Easter Seals, who suffered a brain hemorrhage at birth, but who has made tremendous progress under the care of neurosurgeon Francis Rocket. Mary and her parents now fear losing Dr. Rockett who, along with other Massachusetts doctors, has considered relocating because of high medical malpractice insurance costs.

In our earlier hearings, we met another neurosurgeon who feared comforting a grieving patient because he might be seen as guaranteeing success.

We have heard how claims paid by one insurance company tripled in just 4 years. Even the legal community has suffered new blows to its reputation.

But just as we are all victims, we are all part of the problem, too. To put it simply, part of the reason we have a malpractice crisis is because there is too much malpractice; and we have too much malpractice because the medical community engages in too little risk management and self-policing. In turn, the legal community has overreacted.

Testimony indicated that two-thirds of claims are disposed of without payment. And in at least one State, the burden of proof has in effect been turned around to make doctors prove they are not guilty of malpractice. Of course, lawyers are responding to the demands of patients, who have come to expect medical miracles—and compensation for anything less than medical miracles.

Finally, we heard testimony about inequitable insurance rating, unwise financial management, and other overreaching practices.

It is time to stop talking about victims and culprits and start talking about solutions, and that is what we are going to try to do here today. We will hear from experts on both coasts on how their States have handled this crisis And of course, we will hear from our HHS Secretary Bowen in a dual role—both on how he approached this problem in the Nation's breadbasket and on the administration's views to this very serious problem.

As we search for answers, I just want all the parties to know that since they are part of the problem, I expect them to be part of the solution. We can turn this tragedy into a triumph of the greatest medical and legal systems known to mankind, but only if we stop the finger-pointing long enough to join hands and work together.

At this point we will receive for the record a statement by Senator Kennedy.

[Senator Kennedy's prepared statement follows:]

from the office of
Senator Edward M. Kennedy
of Massachusetts

STATEMENT OF SENATOR EDWARD M. KENNEDY
ON THIRD HEARING ON MEDICAL MALPRACTICE

September 11, 1986
For immediate release

Over the last few years a liability crisis has gripped many states and communities around the country. In some states, the effect on medical malpractice insurance rates has been especially pronounced. Many much needed practitioners are retiring prematurely from the practice of medicine. Patients find themselves without access to physicians they have long relied on.

In response to this crisis, in the first few months of 1986, tort reforms were passed in 12 states and were pending in 31 states and the District of Columbia. Today, in this third hearing before the Senate Labor and Human Resources Committee, we will hear from representatives of three states that have enacted legislative reforms addressing the crisis in an attempt to reduce its impact on the price and practice of medicine. Though the programs enacted by these three states overlap in some respects, they also differ in significant features. Testimony from Massachusetts, Florida, and California about these reforms will provide us an opportunity to obtain a broad overview of the medical malpractice crisis and solutions to it.

Federal legislation for the malpractice situation has also been proposed and will be addressed at this hearing. Some states are in favor of federal legislation. Others oppose it. In previous hearings before this Committee, expert witnesses have pinpointed omissions from the bills introduced in Congress. We must remember the wise counsel of these witnesses. Their concerns have focused on the need for improved regulation of the insurance industry, and reduction of obstacles to state oversight of the practice of medicine.

We must move to carefully define the appropriate federal role in the malpractice crisis. Today's hearing will provide additional basis for our consideration of this issue.

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The CHAIRMAN. We are very, very happy this morning to have with us the Secretary of Health and Human Services, Dr. Bowen.

Dr. Bowen, we always look forward to welcoming you and your staff to this committee. You have a number of excellent staffpepole with you. We know them, but you may want to introduce them to everybody here.

We welcome you to the committee. We appreciate the work you are doing there. We appreciate your particular interest in this subject and your particular knowledge about this subject as well. So we will turn the time to you.

STATEMENT OF HON. OTIS R. BOWEN, M.D., SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY RONALD ROBERTSON, GENERAL COUNSEL; RONALD F. DOCKSAI, ASSISTANT SECRETARY FOR LEGISLATION; DON M. NEWMAN, UNDER SECRETARY; AND S.J. PLAGER, TASK FORCE CHAIRMAN

Secretary BOWEN. Thank you, Mr. Chairman.

Accompanying me this morning are the general counsel of our Department, Mr. Ron Robertson; our Assistant Secretary for Legislation, Mr. Ron Docksai; the Under Secretary, Mr. Don Newman; and the chairman of our task force, Mr. S.J. Plager.

When I last appeared before you, Mr. Chairman and members of the distinguished committee, you asked me to highlight my list of priorities as Secretary of Health and Human Services. I appreciate the opportunity to appear before you today to discuss an issue that ranks near the top of that list, and that is of course, the problem of medical liability and malpractice insurance.

Mr. Chairman, in the interest of time, I will summarize my remarks and ask that my longer statement be inserted in its entirety in the record.

The Chairman. Without objection, we will put your full statement in the record, and we will do so for all witnesses today. We hope everybody will summarize.

Secretary BOWEN. I commend you, Mr. Chairman, for your leadership in introducing the Federal Incentives for State Health Care Professional Liability Reform Act, holding these hearings and indeed beginning a dialog which should be considered the opening salvo in Senate debate on malpractice insurance.

We owe you and other sponsors of the legislation our deepest thanks and appreciation.

My conviction on this issue runs deep. Indeed, I have been exposed to the gravity of this problem—a physician, as a consumer, as a former Speaker of the Indiana House, as Governor, and now as Secretary of Health and Human Services.

I can say with certainty that there clearly is a problem with liability insurance in this country; on that much, we all agree.

We have seen rising premiums, increasing awards, growing caseloads. We have seen what appears to be disproportionate geographic impact with physicians in States such as Florida, New York and California paying multiples of the rates their colleagues in other States enjoy.

We have seen a disproportionate impact across health care specialties, with OB/GYNs, anesthesiologists, neurosurgeons and surgeons, to pick a few, paying rates far in excess of other kinds of health care.

While there is no comprehensive data on whether the current malpractice dilemma threatens access to care, a number of specific examples revealed by the most recent survey we took reveals that it does. For example, we have all heard countless stories about obstetricians leaving practice. We have found that community health centers in Missouri and Michigan have had to discontinue their OB services because they could not renew their liability insurance.

To me, this appears to be a clear and present barrier to health care, and that is one very compelling reason for action.

However, the prospect for action on the medical liability issue raises some very fundamental questions. While we all agree that there is a problem, consensus on how great the problem is—for example, whether it is a problem outside certain geographic areas or specialties—and consensus on a solution remain more elusive.

From my study of the issue, I feel there are two aspects to this problem which we must address if we are to solve the medical liability crisis: Adverse trends in tort liability that may threaten access to, and increase the costs of health care; and safeguards to insure that physicians licensed to practice medicine are competent. In addition, we must try to determine to what degree, if any, insurance industry practices may have contributed to the medical liability problem.

How we address these issues is the real question at hand.

My earliest efforts to solve this problem were intended to preserve to the maximum extent possible a States ability to act on its own. My own State of Indiana was at the forefront of enacting a comprehensive set of liability reforms in 1975 when I was Governor. Frankly, I am distressed that few States have seen fit to adopt such legislation, which many experts have cited as being a model for the Nation.

As you are aware, Mr. Chairman, our administration has a profound respect for traditional State prerogatives. Any Federal intervention that would compel States to act or override State policies must be based on truly vital national interests that would be significantly served by Federal legislation. Whether that is the case for malpractice insurance remains unresolved.

The legislative approach the chairman has put forth for study provides financial incentives for States to act. Other bills seek to coerce the States to act. Some have suggested that the Federal Government develop model legislation with an over-arching Federal approach to be considered only as a last resort.

And then, with each of these frameworks there are the details: If you do cap awards, what should be the appropriate level? If there are financial incentives for States, how much should be provided? And so on.

The proposal in S.1804 for periodic payments, rather than single lump sums for large awards, seems like a good idea. This would make funds available only as they are needed. Limiting noneconomic damages makes good sense as well. Calculating lost wages and medical costs to some extent can be determined objectively, while awards for pain and suffering are wholly subjective. It has become more a lottery than a rational system for compensating the injured.

I agree that there is no justification for allowing double recovery for the same injury. Medicare and Medicaid should remain payers of last resort, as current law provides. The bill proposes fee schedules for attorneys similar to those contained in the administration's product liability reform proposals. The purpose of such proposals is to make more money available to the injured individuals and to reduce excessive costs. The emphasis on States to provide more funds for State disciplinary boards is also desirable.

Of course, we share some concerns about the bill: first, we are concerned about the $200 million authorization for financial incentives; we simply cannot conclude at this time that Federal health care expenditures would be reduced enough to offset the increased spending. Also, I am concerned that the bill limits itself to too narrow a set of reforms For example, States that chose to adopt a system such as Indiana's apparently would not qualify for the financial aid. And finally, as I have underscored, we do have very real concerns that the principle of federalism not be breached.

It is clear that no one has the right answer now, if indeed there is one single answer.

On August 28, I announced formation of a Department Task Force in the Office of my Under Secretary, Don M. Newman, to look at these and other crucial issues. I know the committee will be heartened to learn that this group will be cochaired by two very talented men, S.J. Plager, counselor to the Under Secretary, and someone each of you know very well, my new Health Resources and Services Administrator, Dr. David Sundwall.

Let me quickly add that I share the Congress' skepticism over studies which can often serve only to delay. The very fact that we are at a hearing today, rather than a markup reveals the lack of consensus on the issue at this time. However, it does not minimize our sense of urgency about this grave and ever-growing problem.

I have instructed my task force to be an agent for action rather than delay. It is an earnest effort to unite around our common interests in order to provide relief for all who the medical liability issue affects.

We have an ambitious agenda, spanning the range of issues which I feel will complement the GAO studies now under way, and will enhance congressional debate. The task force is expected to conclude its work in the spring of next year.

Finally, let me underline the importance that I attach to both tort reform and quality assurance efforts. If physicians want relief from onerous malpractice liability costs, they must be willing to better police their own ranks and to assist in identifying problem members of the profession.

Once again, I congratulate you, Mr. Chairman and members of the committee, for holding these hearings, and our Department stands ready to work with you.

This does conclude my remarks, and I would be glad to attempt to answer questions at this time.

[The prepared statement of Secretary Bowen and response to questions submitted by Senators Kennedy and Hatch follow:]

TESTIMONY

BY

THE HONORABLE OTIS R. BOWEN, M.D.

SECRETARY OF HEALTH AND HUMAN SERVICES

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

ON MEDICAL LIABILITY AND MALPRACTICE

SEPTEMBER 11, 1986

WASHINGTON, D. C.

Let me begin by commending Senator Orrin Hatch, the sponsor of S. 1804. This distinguished Senator's diligent work on this and other legislation are deserving of the highest plaudits. We owe him our deepest thanks and appreciation.

I appreciate the opportunity to testify on the issue of health care liability. As a physician, former State legislator, Governor, and now Secretary of Health and Human Services, this issue has been of continuing concern to me. And it should be of great concern to every American.

We know that malpractice has meant increased liability costs to health care providers. We know that these escalating costs cause insurance companies to increase premiums, and sometimes withdraw liability insurance. We know that physicians believe they are increasingly and unfairly at risk of being sued. And, at the same time, we know that it is the right of every person to gain redress if they have received improper care.

The frequency of suits against physicians has increased dramatically in recent years; absolute costs of malpractice insurance have gone up at an astounding rate and fewer insurers today market malpractice insurance than five years ago. Increased liability insurance costs have hurt physicians and added to consumers' health costs. They may also be jeopardizing quality and adequate access to health care in some areas. And they may have aggravated the already high levels of unnecessary tests and procedures doctors order in the name of "defensive medicine."

There is truth in much of this.

But, there are a number of issues that we must address if we seek to solve the medical liability crisis, such as:

--the need to address adverse trends in tort liability that may threaten access to, and increase the cost, of health care;

--the need to ensure, as best we can, that physicians licensed to practice medicine are competent.

I cannot reiterate too strongly the need to address these issues in a coherent way. To address one without the other is only half a solution.

I have named a Department Task Force to examine the issues involved and I'll say more about this later.

BACKGROUND

The problems that S. 1804 seeks to address are not new, nor limited to medicine. Medicine's problem came to public attention in the 1960's when both the number of malpractice claims leaped and the size of some awards grew dramatically. In time, this caused premium costs to soar and some insurers stopped offering this coverage.

The situation has steadily worsened, although the general decline has been marked by periods of comparative calm as well as periods of comparative strife.

During one period in the mid-1970's a number of states like Indiana enacted various reforms to their tort system. Also, many physician-owned companies formed to provide liability insurance. But in recent years the problem has once again erupted and created the situation that confronts us today.

Although public attention becomes focused on medical liability during these periods, the fundamental problems do not completely disappear. Instead, there are deep-seated problems that have resulted in the medical liability situation getting progressively worse over the last few decades. Even if the current situation passes, these long-term problems deserve remedial action.

TORT REFORM

The current problem in medical liability is caused not just by factors unique to medical practice, but is part of undesirable trends in liability law in general. These trends are affecting the availability and affordability of liability insurance for professionals, businesses of all types, nonprofit organizations and municipalities.

To address this widespread problem, the White House Domestic Policy Council established a Tort Policy Working Group. Last February it issued a report critical of a number of trends in tort law, with many recommendations.

These are:

- Retain fault as the basis for liability.

- Eliminate joint and several liability, except in cases of concerted action.

- Base liability on credible scientific and medical evidence and opinions concerning causation.
- Limit non-economic damages to a fair and reasonable amount.
- Reduce awards by other sources of compensation for the same injury unless the other payer has a well-founded claim for subrogation or reimbursement.
- Provide for payment of large future damage awards in periodic amounts instead of in a lump sum.
- Place limits on attorney contingency fees.
- Develop alternative dispute resolution mechanisms.

I recommend that this committee review these excellent recommendations.

AN UNEVEN BURDEN

But, we should remember that the burden of increased costs in health profession malpractice insurance has not fallen evenly. Hardest hit have been obstetrics, with anesthesiology and surgery next. These were already specialties with high insurance rates. A 1983 survey we had done by the National Opinion Research Corporation (Physician Practice Costs and Income Survey) showed that no pathologist or pediatrician in solo practice paid more than $10,000 in annual premiums but 56% of the general surgeons, 65% of the OB/GYNs and 69% of the orthopedic surgeons did pay more than these high cost premiums.

There are geographic differences too: obstetricians in New York's Long Island pay much higher rates than those in other parts of the State. And obstetricians in New York and Florida pay multiples of the rates in other States.

IMPACT ON ACCESS TO CARE

There are no comprehensive national data on whether rising malpractice premium costs are affecting access to care. However, we recently completed a survey that found a number of specific examples which suggested there may be problems in some geographic areas and certain population subgroups with access to care.

In general, our survey shows that low-income patients, rural residents, those living in midwestern and southeastern States and those considered to be "high risk"--either because of their medical condition or because they are likely to sue--are more likely to encounter access problems that may be attributed to the current malpractice situation. Of course, these are many of the same groups that have traditionally had more access problems.

Further, the inevitable presence of other factors requires considerable caution in interpreting the examples we found. Nevertheless, the number of examples collected--over 150 in 33 States--gives us cause for concern.

The overwhelming majority of examples of access problems involved providers of obstetrical services--both prenatal care and delivery services. The most common action reportedly taken by these providers that affects patient access is leaving the practice of obstetrics or, in the case of community clinics, discontinuing or reducing their obstetrical services.

The most frequently cited problem was disruption or termination of prenatal care. Community health centers in Missouri and Michigan have had to discontinue their OB services because they weren't able to renew their facility's liability coverage unless they did. And even those publicly financed facilities that could get insurance found they often had to reduce their services because they had to divert income to paying insurance premiums.

INDIANA'S REFORMS

When I was Indiana's governor, I was determined to address the medical liability issue. So at my urging, we enacted a comprehensive set of medical malpractice reforms in 1975. Many say these reforms are more far-reaching than can be found in any other State.

They limit maximum liability for any patient to $500,000, and for any single provider, to $100,000. Any difference between the amount providers must pay and the total award the court grants is paid out of a patient's compensation fund. This fund is financed by a surcharge on the insurance premium of all health care providers in the State.

We also established medical review panels. These consist of a nonvoting lawyer-chairman and three health care professionals who review all proposed malpractice complaints before they can be filed in court. After opportunity for a hearing, the panel renders an opinion that can be introduced in evidence in court if any party chooses to pursue a judicial remedy.

The law limits contingency fees for plaintiffs' attorneys to 15% of any recovery from the patient's compensation fund. Also, all settlements and judgments are reported to the appropriate State disciplinary board.

Indiana's medical liability problem has been greatly eased by this law, according to both public and private officials. Spokesmen for the state medical society, the State Health Department and the State Association of Primary Care Centers all agree that access to medical care is not limited by liability problems at this time because of this law.

But the roots of medical liability run deep and I would be the last to assert that Indiana has totally solved its problem. As witness to that, the number of malpractice claims keeps growing in Indiana. As a consequence, the surcharge on premiums that helps to finance awards has had to be boosted from its original 10% to 100%.

Nonetheless, Indiana's law has achieved its purpose. The State has enjoyed relatively low insurance premiums and the rate of premium increases has been slower than in many other States. More important, it has removed the crisis atmosphere many other States are experiencing as physicians lose insurance coverage, retire or abandon portions of their practice to avoid staggering premium increases.

Indiana's experience tells us that tort reform works. It removes the worst excesses of the current tort system without infringing on the legal rights of injured patients. Indiana has eased the threat of lessened access to health care and its subsequent threat to quality of care.

LICENSURE AND DISCIPLINE

As I noted earlier, the problem we confront has three aspects: tort reform, insurance industry practices and more effective ways to ensure physician competence.

I want to address that third concern now. Our experience with medical malpractice supports the conclusion that a small percentage of physicians are simply not competent to practice while others may not be competent to perform certain procedures.

We need more thorough and comprehensive State surveillance:

- To identify physicians whose competence in specific procedures needs to be upgraded;
- And to identify physicians who are outright incompetent to practice.

Last June, our Department's Inspector General issued a report on medical licensure and discipline. Although State disciplinary actions have increased in recent years, he reports, the process remains underfunded and inadequate.

The inappropriate writing of prescriptions is by far the most common violation, accounting for about half of all disciplinary actions taken by State boards.

The second major type of violation stems from drugs and alcohol abuse by physicians. Although States are cracking down on this, drug-impaired physicians still practice today. This is a matter of great concern to me and the profession.

Only a few disciplinary actions by State boards appear to stem from outright incompetence or careless work. The low number of such cases could be due to the cost and complexity of developing the necessary evidence. But it could also be because physicians are reluctant to tell on other physicians. Whatever the reasons, we simply don't know the true extent of inferior medicine being practiced today or the impact it may have on patient care. We need to find ways of getting at these difficult but important questions.

Of course, State boards are not the only mechanism for monitoring the performance of physicians. The medical profession has a long tradition of peer review. Hospitals, for example, have peer review committees manned by members of their respective medical staffs. These committees make critical decisions on staff privileges and other issues and play an important role in protecting the quality of medical care.

These private peer review committees have been experiencing their own legal problems. Some physicians disciplined by these committees have filed suit, claiming that the peer review committees are violating the Federal antitrust laws. The disciplined physicians allege that the peer review process is being used as a cover for anticompetitive activities.

The plaintiffs often build their case with documents subpoenaed from the peer review committee, including the confidential testimony physicians give on the performance of their peers.

The danger is that fear of antitrust liability will discourage physicians from participating in private peer review. That would be a serious loss. On the other hand, we must think twice before concluding that all peer review should be exempt from antitrust scrutiny. Regrettably, there may be instances in which peer review is inappropriately used.

I have no simple solution for this complex problem, but you should be aware of it. It's an important issue in the area of professional self discipline.

THE ADMINISTRATION'S VIEW OF S.1804

I now wish to turn to S.1804.

It calls for these tort reforms:

- In cases involving future damages over $100,000, recompense could be made on a periodic basis.
- Awards would be reduced by the amount of any other payments from other sources for the same injury.

- Awards for noneconomic losses would be limited to $250,000.

- And plaintiffs attorney fees would be limited according to a specified schedule.

With regard to the competence-to-practice issue, the bill would require:

- All fees for the licensing of health care professionals to be earmarked for the use of the State agencies responsible for their discipline.

- Health care providers would have to have risk management programs.

- Insurance companies would have to make information available to State disciplinary boards on malpractice settlements and awards and to establish programs of risk management for health care professionals.

- And State disciplinary boards would be authorized to contract with local professional societies for medical review of information concerning possible malpractice.

The bill would also encourage states to enact these reforms by providing Federal incentive grants. Under this legislation, a State would be eligible for an initial Federal development grant of $250,000 to help it prepare to implement these provisions; additional grants could total $4 million per State over three years after enactment.

The proposal for periodic payments contained in the bill rather than single lump sums for large awards seems like a good idea. It would make funds available only as they are needed.

Limiting noneconomic damages also makes good sense. Calculating lost wages and medical costs to some extent can be determined objectively, while awards for pain and suffering are wholly subjective. It has become more a lottery than a rational system for compensating the injured.

I agree that there is no justification for allowing double recovery for the same injury. It seems to me that no one can defend windfall gains made possible by compensating plaintiffs twice or more for the same injury. At the same time, Medicare and Medicaid should remain payers of last resort, as current law provides.

The bill, S. 1804, proposes fee schedules for attorneys similar to those contained in the Administration's product liability reform proposals. Within reason, limits on attorney fees are desirable. The purpose of such proposals is to make more money available to the injured individuals and reduce excessive costs. However, I believe it would be a mistake to so reduce attorneys' fees that patients who have suffered from real medical malpractice could not obtain legal counsel with which to secure appropriate compensation.

The emphasis on States to provide more funds for State disciplinary boards is also desirable. The Adminstration's proposals in this area are contained in S. 1323. They would, for example, require State Medicaid agencies to report to our Department any final adverse actions against health care providers by the State's licensing authority, up to and including any loss of license. This information would then be provided by us to Federal and State health care agencies, other Federal authorities and other State licensing agencies.

I do, however, have these general concerns about the bill.

FINANCIAL INCENTIVES

First, the bill calls for financial incentives. At a time when the Federal government must observe budget restraint, the bill's authorization to spend over $200 million raises serious questions. At this time, we simply can't conclude that Federal health care expenditures would be reduced enough to offset the increased expenditures this bill calls for.

Many states have already enacted some of the proposed reforms, and we expect other state changes in the coming year. It is unclear whether the incentive grants would make any difference in encouraging these activities. We are, however, continuing to study the effects that medical liability reform could have on the Federal budget and on other Federal interests.

COVERAGE

My second concern is that the bill limits itself to too narrow a set of reforms. For example, States that chose to adopt Indiana's system still wouldn't qualify for the bill's financial aid even though Indiana's reforms go beyond this bill's.

THE FEDERALISM QUESTION

A general concern of this Administration has to do with federalism and the nature of the federal system itself.

Although there is clearly a problem in medical liability that affects most or all of the Country, we must remember that tort law and medical licensure are areas in which the States have traditionally decided policy. What's more, States are now actively revising their laws on this subject.

This Administration respects traditional State prerogatives. We believe in the principles of federalism. We think that any Federal intervention that would compel States to act or override State policies must be based on truly vital Federal interests that would be served in a significant way by Federal legislation.

Certainly, a Federal interest is to contain the cost of health care, a major concern because Medicare and Medicaid account for about 10% of the Federal budget. Reducing excessive malpractice insurance costs and eliminating unnecessary defensive medicine practices might well reduce Federal health care expenditures.

Impaired access to health care is another issue that may justify Federal action if it materially affects the beneficiaries of Federal programs. Beyond that, I am vitally concerned about the quality of care available to all of our citizens. Their health is a matter of national importance.

MORE STUDY NEEDED

To answer these and other crucial questions, I've set up a Department Task Force to take an in-depth look at malpractice issues. This group will work out of the Office of the Under Secretary. It will be co-chaired by S.Jay Plager, counselor to the Under Secretary, and Dr. David Sundwall, Administrator of the Health Resources and Services Administration.

Preliminarily, the Task Force will look at five general areas:

First, it will examine the impact of existing compensation systems on the delivery of medical services, and the levels of compensation for injuries caused. Specifically, we need to know the extent to which the practice of medicine is positively or adversely affected by liability rules.

Second, we will examine the applicable laws and legal rules governing the compensation for medically caused injuries. Our effort will include a review of actions taken by the several states, including the experience in Indiana.

Third, we will examine the development of structures and procedures to ensure the quality of medical practice. We will survey the practices and experiences of the several states regarding licensing, monitoring, and sanctions that attempt to ensure the competence of medical practitioners.

Fourth, we will examine the role of the insurance industry, public and private, as it attempts to protect both provider and beneficiary. We will try to determine to what degree, if any, insurance industry practices may have contributed to the malpractice liability issue.

Finally, we will identify a national research agenda.

For example, we're conducting a national survey of physicians to find out how their liability coverage has changed since 1983.

We want to know whether malpractice insurance costs have increased as a proportion of gross practice income, or if physicians in certain specialties and geographic locations have incurred disproportionately large rate increases, or if medical practices have been altered by any changes in the cost of malpractice insurance.

Another study will compare physician practice patterns in Indiana with those in five other States that haven't enacted tort reforms.

Researchers from Tufts University and the Rand Corporation will also look into ways to deter medical malpractice. They will analyze claims data dealing with negligent behavior and examine ways to detect and penalize high malpractice risk physicians.

Until the Task Force completes its activity, I will not be able to conclude what the proper Federal role is concerning these most important issues. We will continue to research the issue and monitor developments to determine whether a more active role for the Federal government would be appropriate.

The research we have underway will also prove useful to States as they continue to examine how best to address malpractice so as to assure constantly improving quality of care. While we explore these questions it's my strong hope that states will continue to explore tort reform and strengthen licensing and monitoring of all health professions.

Finally, let me once more underline the importance I attach to both tort reform and quality assurance efforts. If physicians want relief from onerous malpractice liability costs, they must be willing to better police their own ranks and to assist in identifying problem-members of the profession.

Thank you.

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S. 1804

FEDERAL INCENTIVES for STATE HEALTH CARE PROFESSIONAL LIABILITY REFORM ACT OF 1985

PURPOSE

To address the rising trend towards defensive medicine due to the problem of increased medical malpractice litigation and the resulting additional expense, and the sometimes unavailability, of medical liability insurance for physicians, dentists, nurse-midwives and other health professionals. This poses a serious threat to the accessibility of affordable health care services to the American public.

MAJOR PROVISIONS

The legislation will establish monetary incentives to encourage states to adopt further administrative improvements in this area and four tort law reforms.

Development Grants:

- Provide funds to states as an incentive for them to improve their health care malpractice compensation and professional disciplinary systems.

Incentive Grants:

- Provide $2 million in the first year and $1 million annually for the next two years to any state that adopts all recommended measures. These funds could be used for a broad variety of public health programs, or to conduct studies of the professional liability problem in that state.

Tort Reform:

- Periodic payment of damage awards over $100,000.
- Eliminate the collateral source rule; thus providing for the reduction of awards received from other sources for the same injury.
- Limit non-economic damages (pain and suffering) to $250,000.
- Limit attorney's contingency fees.

Administrative Changes

- States will allocate an amount equivalent to that collected from physician licensing fees to the state agency responsible for disciplinary actions.
- States will require hospitals to develop risk management programs and require physician participation as condition to receipt of insurance.
- States will require insurance companies to make certain data available to state agencies.
- Encourage increased peer review by state medical societies of questionable practice patterns.

Estimated Cost

The legislation is estimated to cost $224.9 million for a three year period.

Estimated Savings

If fully implemented, the legislation is expected to save $500 million annually.

QUESTIONS FOR SECRETARY BOWEN, SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES, SEPTEMBER 11, 1986.

KENNEDY

1) Q: Do you agree that complete disclosure by the insurance companies is necessary before we can design a solution to the current malpractice crisis? Without data it's difficult to predict what effect the various reforms have on the system.

A: The malpractice system has several component entities: doctors, lawyers and insurers. In order to understand the ways each of these entities interact, we need sufficient data. Data can be obtained by retrospective review, prospective analysis or empirically. Data on insurance practices, whether it be premium prices, claims made or payouts rendered, is important and some of it is currently obtainable. (See e.g., GAO Report, HRD-86-112, just released.) But that is not to say that data gaps do not exist. The Task Force will examine the role of insurers and State regulation of insurance in this area, and recommendations, if warranted, will be included in the Task Force report.

KENNEDY

2) Q: I'm seriously concerned about doctor discipline. As you know only a small percentage of doctors seem to be responsible for a large percentage of the malpractice cases even after excluding the high risk specialties. Also it's of great concern to me that most doctor discipline is drug or alcohol related and not to malpractice. How do you plan to address this major problem?

A: Assuring professional competence is an issue in which the Department of Health and Human Services has great interest. The concept of professionals reviewing the actions of their peers is one to which the Department gives complete support. We also support the concept of improved information sharing of health provider misconduct between the States. As an example, we recently proposed legislation establishing a national data system to collect final actions of State medical licensing boards. We share the desire to encourage the process of professional review and also to increase the availability of information about providers which we hope will ultimately improve the quality of care delivered in the United States.

The HHS Inspector General recently reported that medical malpractice cases involving incompetency are among the most difficult kind of cases to develop. There seems to be at least three major factors involved: (1) the complexity, length, and cost of cases on alleged incompetency, even when a malpractice judgment has been rendered (2) the substantial burden of proof that tends to call for "clear and convincing" evidence rather that the "preponderance of evidence" and (3) the considerable variatons among physicians themselves about what constitutes acceptable practice in many facets of medicine.

In the period 1983-85 over 1300 health providers were sanctioned or excluded from the Medicare program, about one-third or 400 of them were physicians. These cases involved imcompetency over and above alcohol and drug abuse. So we are making some progress with a difficult problem.

KENNEDY
3) Q: From the data that we have enacted tort reform very few if any have resulted in improving the problem. Do you feel that the tort system is the problem? In fact no studies as far as I am aware have demonstrated that tort reform has resulted in lower insurance premiums except where the insurance company is not for profit.

A: The impact of tort reform, at least in some States, of which Indiana is an example, has been to slow the rate of increase in the insurance premiums. Those reforms have removed the crisis atmosphere many other States are experiencing as physicians lose insurance coverage, retire or aboandon portions of their practice to avoid staggering premium increases. We think that tort reform is certainly a part of the issue that needs examining.

HATCH
4) Q: I think it is appropriate that your malpractice insurance Task Force plans to review the role of the insurance industry in the malpractice insurance crisis. Several witnesses have testified that the primary reason for the crisis is the cyclical nature of pricing by the insurance industry. They say that the industry lowers its premiums to attract premium dollars when interest rates are high and that prices go up when interest rates go down. Does your Malpractice Task Force plan to address this specific allegation?

A: Yes, the Task Force will examine the relation, if any, between insurance industry practices and the availability and affordability of malpractice insurance.

HATCH
5) Q: You have mentioned the discrepancies in malpractice insurance rates charged different types of specialists in different parts of the country. To correct these discrepencies several of our witnesses have advocated an experience rating system for malpractice insurance, with doctors who have lost malpractice claims being surcharged on their insurance policies. Will your Task Force focus on the efficiency and fairness of such an experience rating system?

A: Yes, the Task Force will examine a number of insurance innovations as applied to malpractice; experience rating being one of them.

HATCH
6) Q: Will your Task Force look into the allegation that plaintiffs' lawyers are encouraging disappointed patients to file frivolous claims and that the insurance industry is settling the claims rather than contesting them in court?

A: The Task Force will attempt to identify and weigh any data which might address the assertion that the plaintiff's bar does or does not encourage non-meritorious litigation.

HATCH
7) Q: Finally, we have received extensive testimony about the pros and cons of the insurance industry's antitrust exemption. Will your report focus on the efficiency of that exemption and whether State regulation of the insurance industry has been satisfactory during the current malpractice insurance crisis?

A: The Task Force will look at data assessing the effect of modifying either partially or totally the current antitrust exemption for che insurance industry.

HATCH
8) Q: Do you have a firm timetable for completion of your Task Force report?

A: The Task Force has an ambitious but tight time schedule. The report is to be submitted to me by February 15 of next year, and within 30 days, I will select a package of proposals and announce Department positions and policies.

HATCH
9) Q: In your testimony you indicated that Indiana's medical liability problem has been greatly eased by the state law. Will you kindly provide relevant statistics for the three years prior to enactment and for the period post enactment relating to numbers of claims, average jury verdict awards, average settlement amounts, average cost per case filed, and other vital statistics commonly used in evaluating medical malpractice problems.

A: I am pleased to attach an article I wrote in 1983, "Medical Malpractice Law" in Indiana for the Journal of Legislation, University of Notre Dame Law School, as well as a letter on this subject I recently received from Mr. Harry E. Eakin, Commissioner, Department of Insurance, for the State of Indiana.

Additionally, the GAO's September 1986 report, Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals, (GAO/HRD-86-112) shows that Indiana's medical liability problem to be far less severe than most other States.

HATCH
10) Q: You state in your testimony that Indiana has enjoyed relatively low insurance premiums and lower increases than many other States as a result of your relevant legislation. Will you kindly provide a comparison of insurance rates between other States and Indiana insurance rates plus the surcharge required in Indiana so that we can have a true comparison of costs?

A: The Department does not, at this time, have independent data on this subject. The GAO's September report, Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112) compared and reviewed data on insurance rates and premiums. The GAO Report substantiated my own personal belief that Indiana has enjoyed lower premiums and lower increases than many other States.

HATCH
11) Q: In your testimony you criticize financial incentives to the States. Is there a better way to encourage State action, and, if so, what is it?

A: We have to carefully compile the costs to the Federal Government of financial incentives to the States and whether there are more cost effective alternatives. This will be one of the important subjects to which the Task Force will give attention.

The **Chairman**. Thank you so much, Mr. Secretary.

You stated in your testimony that a number of States have already enacted many of the malpractice insurance provisions that we have in this particular bill, and that you expect other States to make similar changes.

Together, do you think that these State actions will go far enough so that we will not have to have a Federal solution or a Federal bill?

Secretary **Bowen**. Well, it is my hope that that would be the case, but I am not very optimistic. Back in the seventies, when the problem was so great, I thought that the States would attempt to find solutions, but very few have done so, and those that have, have done it in an inadequate manner. It seems to me that we should go further.

But I still respect the federalism concept, and I still would prefer that the States handle it on their own, but they may need a little nudging one way or another to get it done.

The **Chairman**. Would your office provide us a list of the States other than Indiana which have enacted this type of legislation, and maybe what we ought to have is a compilation of just exactly what has gone on in this area; could you provide that to us?

Secretary **Bowen**. Yes, we will provide that for you, but that will be a part of the task force that we have created. It will be a part of their agenda to determine what has happened and the effects of what has happened in the various States.

[The list referred to follows:]

Listing of State Activity in the Malpractice Area

In the meantime, I have attached a copy of "Summary of 1986 Medical Malpractice and Tort Reform Laws" prepared by Kathleen M. King for the Intergovernmental Health and Policy Project at the George Washington University, September 29, 1986.

The **Chairman**. OK. In the States that have enacted tort reform and malpractice reform, have such enactments actually resulted in a decrease in insurance premiums or just maintaining the status quo?

Secretary **Bowen**. I think that it has not resulted in decrease, but it has stabilized the——

The **Chairman**. The rate increases?

Secretary **Bowen**. That is right.

The **Chairman**. OK. Now, you stated that the reforms of Indiana's Tort Reform Act go beyond those of this particular bill, S. 1804. Could you give us just a little bit of information on why you say that?

Secretary **Bowen**. There are three areas, I believe, that go beyond what S. 1804 does. One is that it does establish an upper limit for the amount that can be recovered, and that upper limit is $500,000. There also is a time limit in which a suit can be brought, and that time limit is within 2 years of the time of the malpractice, with one exception, and that is, for children, it can go up to the age of 8 years. And third, the review panel which is mandatory in the Indiana law studies the issue and within a 6-month period of time, renders an opinion as to whether it was truly malpractice or whether it was not, and that opinion is admissible in court.

The CHAIRMAN. Now, you mentioned the need for greater licensure and disciplinary action in order to assure physician competence. Do you think that stricter physician discipline coupled with a Federal tort reform bill, modeled on the Indiana act, would solve the Nation's malpractice crisis, or would even more extensive measures be needed?

Secretary BOWEN. I think it would go a long way toward helping, but I do not think I am prepared, really, to say it would solve all of the problems, however, it certainly would be a big improvement.

The CHAIRMAN. Well, traditionally, physician licensing and discipline have been the domain of State boards and professional peer review committees. Short of Federal intervention, is there any way to ensure that we put teeth into these peer review and licensing provisions or activities?

Secretary BOWEN. Well, physician incompetence takes about two different forms. One is the writing of inappropriate prescriptions. About 50 percent of all of the disciplinary actions are a result of that. Another is the alcohol and drug abuse problem. Really, there are very few outright incompetent and careless physicians. Those that are, of course, get the headlines, and there should not be any, and that is one of the things that we need to deal with. That problem can be dealt with, I think, through several methods. The medical profession itself, through their own peer review efforts. However, one of the problems there is that one physician reports on another, and then that second one sues the first one, and there is a reluctance, then, to do that. It seems to me that perhaps some good samaritan type act would be beneficial to protect the whistleblower, so to speak.

The CHAIRMAN. We have other Senators here who would like to ask questions. I would just like you to make sure that your task force report will be on a firm timetable so that we can get the information back as soon as we can.

Secretary BOWEN. Our goal on that is to have the report completed by about February 15, and within 30 days, at least by early spring, to have some concrete recommendations to make.

The CHAIRMAN. Thank you.

I will turn to Senator Nickles at this time.

Senator NICKLES. Thank you, Mr. Chairman, and Mr. Secretary, thank you.

I apologize for missing part of your statement, but I think I caught the thrust of it. Also, I had a chance to kind of glance at some of the changes that were made in Indiana—I guess they were made when you were Governor?

Secretary BOWEN. Yes, sir.

Senator NICKLES. I compliment you for that.

The task force is supposed to finish their recommendations by February?

Secretary BOWEN. By the middle of February, yes, Senator.

Senator NICKLES. Will they be coming up with—and this is kind of, I guess, a follow-on of Senator Hatch's first question, and I do not guess you can—are you looking at a Federal solution, or again, are we just trying to encourage the States, or will it be a combination of both?

Secretary Bowen. Well, that is really the purpose of our study. There is no consensus that I can find anyplace in the country about what should be done. As I mentioned, just the very fact that this is a hearing and not a markup means that even in Congress there is a great diversity of opinion.

So, we shall study and make every effort to hit all of the issues, and by the middle of February, have the report completed, and then 30 to 45 days thereafter, we hope to come up with some definitive statements as to what we think should be done.

Senator Nickles. And in those statements, it may well include some legislative proposals as well?

Secretary Bowen. It very well could.

Senator Nickles. Would those be pretty much directed, I guess, from your shop, that would deal with medical malpractice, or would it be more encompassing with the entire liability problem that we face?

Secretary Bowen. Well, it would deal, I think, with both of the issues, but predominantly on the malpractice issue.

Senator Nickles. OK. I was glancing at some of your statements concerning Senator Hatch's bill, 1804, that encourage the States and I guess puts some carrots for the States to make several positive changes, many of which you have agreed to. Were there any that you are particular opposed to? I have not quite gone through all of it.

Secretary Bowen. Well, our concerns, of course, are mainly with the financial incentives, on the $200 million to be appropriated. I am not sure we would be able to reduce the cost of medical care to the Government to $200 million to offset the figure——

Senator Nickles. The $200 million would be what, if each State took full advantage?

Secretary Bowen. I believe that is right. I think that it probably limits itself to a little too narrow set of reforms. I think we should have time limits on when a suit could be brought, and perhaps upper limits on the amount of the suit. Of course, remember I am a little prejudiced here to Indiana's law, but it has worked well and has stabilized the premium level. And our inquiries in Indiana as a result of the law have shown no evidence of access to care denied.

Senator Nickles. Let me ask you one question on the access to care. One of the concerns that I have dealing with this issue is finding a significant number—and I do not have a percentage, and maybe you could give that—but particularly of obstetricians, gyneologists, and others who are getting out of the business, who are not going to deliver babies, who are not going to do a particular type of surgery or something, just because it is prohibitively expensive.

One example comes to mind. We had a physician from a rural Oklahoma town. His premiums—and I am trying to pull them out—and I think Oklahoma's rates were relatively low compared to many other States—but they were doubling, I think, going from 7 to 12 and he thought, to 20, and he only delivered a few babies a year, and it just was not economically viable, and therefore he was no longer going to provide those services. And expectant mothers were then forced to commute as much as 80 miles roundtrip to provide those services. That is a concern, because again of access to care, again a concern of quality of care; those services just not being provided. And certainly, in a case like that, time is critical.

Secretary Bowen. Well, there is no statistical evidence at this time that access to care is a big problem. It is only anecdotal evidence, but there is enough of it that it makes us want to look further into it. It is true that the problem exists mainly in the area of obstetrical care, both in the prenatal and in the delivery. Many obstetrical physicians and family physicians have stopped the delivery and prenatal care, and this would affect the patients' need to travel long distances at times to get their care.

In rural areas, there is more anecdotal evidence that access to care is a problem. Also, there is suspicion that perhaps some of the poor and high-risk patients, and also in the Midwestern and Southeastern States, it seems to be a little bit more prevalent. But that is one of the things that we are going to try to dwell on in our study.

Senator Nickles. I appreciate that. Let me just tell you that we have had hearings on this issue in my State, and that is a very significant problem, the fact that many physicians in obstetrics and child delivery are just getting out, and so it is a real serious problem. That figure that I used of 80 miles roundtrip for services was given in our hearing, and it is happening not just in this one community, but it is happening in several places, and so I hope that it will be addressed.

Dr. Bowen, there is one final question, not directly related to the malpractice issue. But I have discussed with you and other members of the Department at times in the past about the discrepancies between reimbursements and varieties, primarily between urban and rural, both in physicians and hospitals in my State, and I am sure it applies in many other States as well. We have been trying to see if we could not make one for physicians, a unified rate in our State, and second, for the hospitals, to eliminate some of these discrepancies—one example being for pneumonia. One small hospital's reimbursement was $1,400; a hospital 40 miles away from a little larger community that had a higher debt service is $2,800—exactly double, and the services provided certainly, in my estimation, would not warrant that type of discrepancy. And I see that almost growing and causing an undue fiscal burden on some hospitals that maybe were more tightly managed or fiscally prudent with their dollars, that did not incur the debt loads, are really being punished, and the same thing with the physician reimbursements. Again, I will use this 20-mile example. One physician has two offices, one in Oklahoma City, one just outside of Oklahoma City. In one, he is reimbursed in the rural area $11 for an office call; $18.40 in the urban area.

These kinds of discrepancies, I think, are putting a lot of burden on the rural areas and encouraging all the medical facilities, hospitals, and physicians to go to the urban areas, and I think we need to be addressing that or at least looking at it.

Secretary Bowen. As you are well aware, Dr. Roper, our new head of HCFA, and I have had many discussions on this, and we are studying it very carefully and hope to have a little more uniformity in the method of paying. The rural versus urban is a real problem, and as I say, we are studying that.

Senator NICKLES. Well, I appreciate that. I worked with Carolyn Davis on it for some time, and we have contacted Dr. Roper and we will do the same.

Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Grassley.

Senator GRASSLEY. Mr. Secretary, I am sorry that I was not here to hear your testimony, but it is my understanding that you have made references to the need of the medical profession to do a better job of removing problem doctors from practice, and of course, physician review activities are essential to assuring that competence.

Now, it seems to me that the legal system is placing physicians in a catch-22 situation because antitrust sits are being brought by physicians who are disciplined based on the review of their colleagues. It is my understanding that the Astoria Clinic case in Oregon has had a chilling effect on peer review activities at a time when we are asking physicians to expand self-regulation programs.

So my question to you, Mr. Secretary, is whether we should provide physicians that participate in legitimate peer review programs greater legal immunity.

Secretary BOWEN. I think that they do need some protection, and as I mentioned earlier, a "Good Samaritan"-type law to protect them would be very beneficial in getting a physician to "blow the whistle" on someone who was incompetent in practice.

Senator GRASSLEY. So do you find yourself in a position where you would be asking them for that greater legal immunity, since you see a necessity for it?

Secretary BOWEN. We have established a task force within our Department to study every one of these issues, and by February 15, the report is due to my office. Within 30 to 45 days, or at least early next spring, we hope to have some concrete recommendations, and I will be surprised if that is not one of them.

Senator GRASSLEY. OK. So then, that more or less would put you in that position, then, if the task force was positive in regard to what you thought was needed of being in a leadership role on that?

Secretary BOWEN. Yes.

Senator GRASSLEY. OK. Of course, there is unanimous support for stronger disciplinary systems, and I am, of course, pleased to note that the American Medical Association has initiated expanded self-regulation programs. But even if we were to remove every bad physician—and I know that is a nebulous sort of definition—but if we were to remove them from practice, would physicians continue to experience problems with professional liability insurance? And maybe while I am asking that, I also ought to ask, isn't a stronger disciplinary system just one aspect of the approach that we need to take to respond to the professional liability crisis?

Secretary BOWEN. The answer to that is yes, it is just one part. But as the AMA and as I have stated, the medical profession cannot expect any help until they are able to police themselves to the maximum amount.

Actually, there are very few outright incompetent and careless physicians, but those who are, of course, should not be in the practice. They also get the maximum amount of public attention, so it sounds like a lot more are incompetent than what there are. Surely, someone with a bad medical result is not always due to the fact that the physician did not treat the individual right. For example, if you have a crushed elbow, I do not care how good the specialist is, you are still going to have a stiff elbow in the end. But when you hold that stiff elbow up in front of a jury, it gets a lot of sympathy.

So, those types of problems will continue.

Senator GRASSLEY. Well, let me follow through on that in regard to the fact—and I assume that the statistics are correct that 73 percent of the ob-gyns have been sued. Now, of course, I find it difficult to believe that three-quarters of the obstetricians were guilty of malpractice or incompetent. Is it kind of a case of physicians often successfully being sued for bad outcomes rather than for actual malpractice?

Secretary BOWEN. I do not know what the percentage is, but certainly, three-fourths of the obstetricians are not bad physicians; they do competent work. People expect miraculous things from medicine anymore, and I think that the practice has also been a little more impersonal. Physicians do need to work at their own public relations effort with the patients to develop the proper rapport so that, even though the result does not come out perfect, they are not sued if it is not the physician's fault.

Senator GRASSLEY. I thank you for that clarification.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Grassley.

We want to thank you, Mr. Secretary. We appreciate you and your colleagues and staff members being here today. We appreciate the articulate testimony you have given, and we look forward to hearing more from you on this issue as we work on it together.

Secretary BOWEN. Thank you very much.

The CHAIRMAN. Thank you, Mr. Secretary, and I thank all of you.

[Additional material supplied for the record follows:]

MEDICAL MALPRACTICE LAW
IN INDIANA

written in 1983

for

Journal of Legislation

University of Notre Dame Law School
Notre Dame, Indiana

by

Otis R. Bowen, M.D.
Professor, Department of Family Medicine
Former Governor,
State of Indiana
1973 - 1981

I. NEED

In 1974 in public remarks I began to stress the malpractice insurance problems in our state. I viewed it as one of the issues that had to be faced by the 1975 General Assembly. My concern was legitimate as indicated by findings of the 1975-76 Medical Malpractice Study Commission which found:

1. The average premium for physicians increased 410% from 1970 to 1975.

2. Insurance companies writing medical malpractice insurance for physicians had operated at a loss in writing medical malpractice insurance in Indiana for the years 1970 through 1974.

3. The frequency of claims filed against physicians had increased by 42%. In 1970, one in 36 physicians had at least one claim filed; in 1975, one in 21 physicians had at least one claim filed.

4. The average awards had increased over the years 1970 to 1975 as demonstrated by the following table:

Year	Average Award
1970	$12,993
1971	20,498
1972	42,869
1973	31,299
1974	18,320
1975	34,297

5. 65% of the physicians ordered procedures they considered superfluous for fear of being sued.

6. 41% of the physicians routinely ordered procedures which they considered to be completely superfluous because of the fear of being sued.

7. X-rays were the most commonly ordered procedure which the physician considered superfluous.

8. 57% of all lawyers felt there was not more malpractice in Indiana at that time as compared to before January 1, 1970.

9. One third of all lawyers handled medical malpractice cases.

10. Office fees of physicians increased 45% from 1970 to 1975.

In addition, the commission found that malpractice claims had increased because:

1. Patients were more aware of medical malpractice and the legal redress available to them.

2. Patients had developed greater expectations for complete cure and their disappointments lead to suits.

3. There was strong indication that the increasing deterioration of the rapport between doctors and patients had led to an increase in malpractice claims.

Further, in the minutes of the Medical Malpractice Study Committee of September 11, 1975, Mr. Hudson who was Insurnace Commissioner at that time stated there was a 232.4% increase in the amount necessary to settle malpractice claims from 1974 to 1975 in Indiana by one of the major insurance companies.

In my State of the State address, I stressed the urgency to find a statutory answer. I asked the legislators to act and not delay. I did not recommend a specific method to resolve the problem for there were undoubtedly many ways'it could be responsibly addressed.

There were many reasons for the near crises: continually increasing malpractice claims costs both from the standpoint of severity or average cost per case, and, to a lesser degree, the number of cases; rapidly rising malpractice insurance premiums which left some physicians, especially those in high risk specialties, without or at least with inadequate coverage; some primary care physicians taking early retirement in areas which were already in short supply; surgeons ceasing to do the more complicated cases which entailed more risk; and hospitals discontinuing some emergency services and canceling some types of surgery.

The origin could go back to the end of World War II as a result of the explosion of medical knowledge and the consequential increase of specialization. Patients had less reluctance to sue a specialist than their family doctor. They expect so much from a specialist and know him less well.

In addition, with increased specialization there was the feeling that care was often less intimate and was being replaced by cold technology and focused on the organ system instead of the whole person.

Further there are now a lot of new types of suits such as "wrongful life," "wrongful birth," and "wrongful conception." Advances in medical science have forced the issue upon the medical profession. The medical profession has taken pride in the fact it can diagnose fetal sex and intrauterine fetal defects. Courts and commentators have popularized the terms and I suspect have put the thought into minds of some who otherwise would not have given a second thought to the subject. These are actions that are bringing about awards for damages because of the birth of a physically or mentally handicapped child.

The conclusion must be that any physician who undertakes pregnancy care has the responsibility of assessing genetic risk, to test and test correctly for fetal defects. Obviously this will be expensive and counter to cost containment.

Seven of ten insurance companies that wrote most or all of the malpractice policies in the state stopped writing new policies, canceled others or limited their new business and their liability. They blamed more law suits and higher jury awards.

In 1975, in the United States, there were 20,000 malpractice claims filed. For those that were "in hospital origin" and that went the full route to a jury, the average award was $350,000.

These were factors that neither the entire health care delivery system nor the public could bear.

The cure in my judgment was legislative. However, it was evident that a legislative cure was unlikely unless many people were involved to include those in the malpractice insurance business, attorneys - both defense and claims - and physicians but most important of all were the health care consumers - the patients - the people themselves. They had already become acquainted with the problem but didn't know what they could do about it. So, it wasn't too difficult to arouse them to action. They responded with letters, phone calls, attendance and testimony at open hearings. They got the message to their legislators that they should not come home until they had solved the problem.

They also realized that if a law were to be effective it had to deal with the amount for which a suit could be brought and the time in which it could be filed.

It was successful because we were able to convince the citizens that it was not a problem for insurance companies; it was not a problem for physicians; nor was it a problem for lawyers. The public, and for that matter most of those associated with finding a solution, did not want a bill that would one-sidedly benefit the insurance companies, the lawyers or the physicians but that it should benefit the public.

We tried not to permit fingerpointing as to causes. There was need for intelligent thinking and common sense. It is interesting that when the final bill was enacted that none of the three professions liked every part of it. That was probably a sign it was a reasonably good bill and a tribute to the legislators who worked on the bill and secured its passage.(1.)

II. LEGISLATIVE HISTORY(2)

The original bill was House Bill 1460 authored by Representatives Dobis and Zirkle with Representatives Warner, Arnold, Larson and Jontz added as co-authors, and sponsored in the Senate by Senators Lundquist and Benjamin with Senators Sheaffer, Bosma and Richard added as co-sponsors. It's title was, "Medical Malpractice: Liability Claims, Review Panel and Insurance."

After its introduction it was referred to the Labor and Economy Committee on February 4, 1975. It was reported out of committee after massive amending and with a "do pass as amended" report. The report was adopted by the House on March 5, 1975. It was "handed down" by the Speaker for second reading and amended again and ordered engrossed on March 7, 1975. It was passed on third reading by roll call #514 with 81 Yeas and 16 Nays, on March 11, 1975 and immediately referred to the Senate.

The engrossed house bill was referred to the Senate Judiciary Committee where everything after the enacting clause was stricken and a new bill substituted. On March 27, 1975 it was reported out of the committee with a "do pass as amended" recommendation. The bill then passed second reading with further amendments and finally passed the Senate on third reading by a vote of 47 to 2 on April 3, 1975.

After the Senate passed the bill with all of their amendments, it was received by the House again on April 3, 1975. The House concurred with the Senate amendments on April 4, 1975 and it was signed by the Speaker of the House on April 10, 1975. I signed the bill on April 24, 1975.

It became Public Law 146.

In the course of events leading to the passage of the bill capacity hearings were held and people from all over the state not only attended but testified. So over-whelming was the first hearing that a number of field hearings were held at various points across the state.

Attorney members of the General Assembly balked at removal of malpractice totally from the jury trial setting and flatly said that no bill would pass unless at least the jury trial function was retained.

Hard bargaining resulted among all the participants and the final bill was hammered out with a true spirit of compromise. Much credit should go to Senator Adam Benjamin, an attorney from Lake County, who seemed to take it on as a special project and did much of the negotiating, rewriting, and shepherding the bill through the legislature. He went on to become a very respected and able member of Congress from the First District of Indiana and suddenly passed away at far too early an age. I have no doubts that his continued long hours of dedicated service under much stress and pressure hastened his demise.

III. CONTENTS OF ORIGINAL BILL

The bill, as originally introduced, was comparable to workman's compensation requiring an arbitration panel thereby taking malpractice out of litigation except for being subject to judicial review. The bill also proposed a statuatory award cap, an attorney's fee limitation and a statute of limitations to deal with the so-called "long-tail of liability."

The digest of the original bill was:

"Adds IC 1971, 16-9.5 to provide for the establishment of a patients' compensation board of Indiana to hear and determine claims for damages which are based on an assertion of medical malpractice; to provide for a schedule of compensation; to establish a statute of limitations; to regulate attorney fees; to provide for a guarantee of financial responsibility for health care providers; to provide for a catastrophic injury fund; and to provide that costs of administration be funded by fixed assessments collected from certain health care providers."

IV. FINAL CONTENTS

The provisions of the 1975 act did not apply to any act of malpractice which occurred before July 1, 1975.

Health care providers, to qualify, had to file proof of financial responsibility with the Insurance Commissioner and pay the 10% surcharge which formed the Patients' Medical Compensation Fund. Proof of financial responsibility was to be established by the health care provider's insurance carrier who filed with the Commissioner proof that he was insured with a policy of malpractice liability insurance. The amount, for a physician was $100,000. For hospitals, 100 beds or under, the amount was $2,000,000 and for hospitals over 100 beds $3,000,000.

The hospital also had the option of submitting an annual verified financial statement that current and future financial responsibilities were sufficient.

The Patients' Medical Compensation Fund was created by the annual 10% surcharge levied on all health care providers.

There was a limit of $400,000 from the compensation fund from which the patient could collect. The aim of the fund was to make money available to compensate permanently disabled individuals some of whom would require lifetime, around the clock care.

If the Commissioner and the claimant, after trial, could not agree on the amount, if any, to be paid from the Patients' Medical Compensation Fund, the court had to determine it.

If the fund exceeded $15,000,000 at the end of any calendar year after the payment of all claims and expenses, the Commissioner had the power to reduce it in order to maintain it at a level of about $15,000,000. All claims computed on December 31 were to be paid by January 15.

All malpractice claims settled against a health care provider were to be reported to the Commissioner by the plaintiff's attorney and by the health care provider or his insurer or risk manager within 60 days. The report had to include the nature of the claim; damages asserted and alleged injury; attorney's fees and expenses; and the amount of the settlement.

In turn then, the Commissioner was required to report the findings of malpractice against the health care provider to the appropriate professional board of registration and licensure. The purpose was to review fitness to remain functioning or in practice. The law stated that the board had the power to censure, put on probation, suspend or revoke a license.

Another important part of the Indiana Malpractice Act was the creation of medical review panels to hear evidence and pass judgment on whether the case was truly malpractice, harrassment or whatever.

The panel decision was to be admissable in court but not be binding. The aim of the panel was to help reduce "nuisance suits" and assist in quicker settlements by avoiding even going to court in many instances.

Either party could request the formation of a panel twenty days after the complaint had been filed. The Department of Insurance was to acknowledge the request.

Within 15 days after filing, the two parties were to select a chairman who was to be an attorney but without voting rights. If they could not agree on a chairman the Clerk of the Supreme Court was to draw 5 names from a list of qualified attorneys. Each party then alternately would strike a name until one was left. Then, within 15 days each party was to select a health care provider and together within 15 more days they chose the third member. The pay was set very meager with each panelist to receive $25.00 per day with the total not to exceed $250.00 each plus reasonable travel expenses. The chairman was to receive $100.00 per day with his total not to exceed $500.00. The panelists were immune from civil liability.

Another feature of the act was to put a limit on contingency fees. Open negotiations were permissible on the first $100,000 which was the physician's liability and a limit of 15% of the Patients' Medical Compensation Fund which had the upperlimit of $400,000.

Another limiting feature was the requirement that a patient had to file the malpractice suit within 2 years of the date of the alleged negligent act rather than 2 years after discovery. There is one exception and that is for children with possible birth injuries. One could file a suit up to age 8 or 2 years after starting school so that discovery would be more possible.

There were other features such as the formation of a residual malpractice insurance authority to insure physicians who could not find an insurance company that would enroll them. This was necessary because new physicians just entering practice could not find an insurance source. They were not eligible for the special state coverage unless they could show that they had been turned down by at least 2 companies. The price of the state insurance was double that of private insurance to keep it from being sought first and thus be in competition with private enterprise. The Authority was empowered to engage in malpractice liability insurance. The insurance commissioner had to appoint a Risk Manager to run the business for the Authority.

Another feature of the program is that one could not sue for a specific amount. The amount of the award had to be determined by the commissioner or judge.

The law also created a commission to observe and recommend timely amendments for corrections and deficiencies.

V. ADMENDMENTS TO ORIGINAL BILL

For such a complex bill surprisingly few amendments of significance have been added. There were a few minor technical ones but those of much import were: addition of classifications of health care providers to include such entities as partnerships, professional corporations, blood banks, community mental health centers, community mental retardation centers, home health agencies and college and university student health centers.

The original medical malpractice study committee which had a "broad base" for appointments expired on schedule on January 1, 1981. A non-code act replaced the original study committee with an "in house" group consisting of legislators and members of the administration.

A 1979 amendment required that each individual who was a member of a partnership or professional corporation must establish financial responsibility separate from the partnership or professional corporation as well as pay the surcharge.

The surcharge was increased from the original 10% to 25% in 1982 as a result of actuarial studies to "beef up" the Patients' Medical Compensation Fund which had been drawn on heavily. The insurance commissioner first expressed concern at the end of 1979 when more money was paid out than received during the year.

The fund paid out $1,972,500 on January 1, 1982 for seven claims which left a balance of approximately $9,100,000 in the fund. According to Carole Hibler, of the Indiana Department of Insurance, at that time there were 908 claims still pending of the 1584 claims filed since PL 146 was passed in 1975. There were 428 cases settled prior to a panel decision and 248 panels had rendered a decision; eight resulted in payments from the fund. Twenty-one payments had been made from the fund without a panel opinion. Of the 908 claims pending, 382 had requested formation of a medical review panel; 444 had not requested a panel and 82 were considered a problem because they did not come under the jurisdiction of PL 146. The total amount paid from the fund from 1975 to 1982 was $9,192,000.

An amendment was enacted in 1976 to change the division of liability between the Patients' Compensation Fund and the health care providers when multiple providers were involved.

An amendment to provide for annual aggregates in the required insurance amounts was enacted in 1976.

As the law was originally adopted insurance companies would have been liable for up to $100,000 of liability for each act of negligence no matter how many acts had been committed. The amendment created an aggregate amount of $300,000 for an individual, $2,000,000 for hospitals with 100 beds or less and $3,000,000 for hospitals with over 100 beds.

Because the annual aggregate to liability was provided, it was necessary to add another section which made the Patients' Medical Compensation Fund liable for the first dollar of an award if the health care provider's insurance company had already paid an amount equal to its annual aggregate limit.

Another amendment in 1976 permitted health care providers to "self-insure." All health care providers except hospitals could "self-insure" for one year by posting with the Commissioner of Insurance a cash or surety bond in an amount of $300,000.

If the health care provider were a hospital, it could qualify by filing a cash or security bond or a verified financial statement.

In 1979 an amendment permitted the health care provider to have a more active part in the settlement of any claim. It did so by adding the health care provider as a party to settlements in addition to the Insurance Commissioner and the insurer of the health care provider.

To expedite a hearing of the review panel, a 1979 amendment allowed the court to order parties to proceed in a speedy manner, to fully disclose relevant information and to allow discovery during the hearings.

In 1982 a $25.00 "medical review panel selection fee" to be paid by the party requesting an at randoom selection of a chairman of the medical review panel was mandated to cover extra expenses in the Clerk's Office.

A flaw was found shortly after review panels were instituted in that there was no time limit in which they should render a decision. This was remedied by mandating a report within 180 days by a 1976 amendment.

In 1977 an amendment was passed to require that the professional board of registration and licensure, to which the Commissioner made a report when malpractice was proved to have happened, had to report its findings, action taken and final disposition back to the Commissioner.

VI. RESULTS

There has been much debate on the bill, but in my judgment and I believe in the judgment of most people the 1975 malpractice law as amended has been good for the people of Indiana, the medical profession, the insurance industry and the legal profession. Complaints come mainly from claims attorneys and that is understandable because of their advocacy in behalf of those individuals who initiate malpractice suits. From a medical standpoint, the law stabilized insurance premiums and enabled physicians to return their full attention to the practice of medicine.

The Insurance Commissioner in a letter to me in response to my inquiry of him on June 29, 1982 said: "It is my personal opinion that the Indiana Malpractice Law is working well; principally because of the $500,000 limit on claims. From my observation, it seems the states that are having problems are the ones that have no limit on malpractice liability."

Dr. Brad Cohen from California during a discussion on malpractice problems said, after hearing Indiana's Dr. Gilbert Wilhelmus at a recent conference of officers of state medical associations: "You have just heard from Dr. Wilhelmus on a trip of Alice through wonderland in Indiana..." Florida's Dr. Vernon Astler said: "We can only say Amen to the California experience. I am amazed at the Indiana picture." Dr. Arthur Mannix of New York concluded (and it is the author's understanding that New York City specialists in Class VII are paying up to $60,000 per year for their required amount of malpractice insurance from some companies), "The real questions facing us are: 'Is the risk of professional liability insurable by any method? And is it affordable?...What is at stake here is the very credibility and integrity of the medical profession itself. Every frivolous suit that is settled begets ten more."

The state's residual malpractice authority's experience has been so good that the rate in 1981 was only 15% above that of the voluntary market place for physicians. Originally 700 were insured by this method. In 1981 there were only 331. When the law was enacted the insurance department reported they were receiving up to 80 calls per day from health care providers seeking insurance coverage and now the Insurance Commissioner has stated that the authority is no longer needed and is advising that it be sold.(3)

The Supreme Court of Indiana upheld the law in May of 1980. The court compared the limits on liability to those of the federal law covering nuclear generator owners. The court said that both cases involved a public need for services rendered by either.

Just after passage of the law there were mixed reactions as expected. They went from one extreme to the other. Some physicians were elated and said they got most of what they were after; others saw the law as a pattern that could end the medical liability crisis across the country.(4)

Others, to include members of the bar were cautious and warned that, "the Indiana law is an experiment and we don't know what it will do." Others were adamantly opposed and talked of ways to overturn the law.(4)

Since it has had time to work, there has been a "narrowing of the gap between lawyer's initial pessimism and doctor's initial optimism." Lawyers seem more reconciled to working within the law(4) but still not without thoughts of removing parts that apply to limitations as to amount, time and pay.

Doctors seem to have continued apprehension that the legislature might weaken the bill and are not quite as sure that its benefits equal their original hopes.(4)

The number of suits continue to be higher and the payments from the funds higher than expected.

Perhaps the law's early chief assets were that, "soon after the law took effect, a freeze on new policies was lifted by Indiana's leading malpractice insurance carrier - The Medical Protective Company, headquartered in Fort Wayne." It took up the "slack left by the temporary withdrawal of another major firm, the St. Paul Insurance Company."(4)

New companies also began writing in Indiana. These facts plus the creation of the Residual Malpractice Insurance Authority, as Steven C. Beering, Dean of Indiana University School of Medicine said, "Made it certain that no one in the state will need to practice without insurance."(4)

Another side benefit appeared to be an increase in the number of M.D.'s practicing in Indiana. In 1975 there were 5,584 physician health care providers registered with the Patients' Compensation Division of the Indiana Department of Insurance; in 1978 it had jumped to 6,772; in 1982 there were 7,070 and on January 1, 1983 there were 8,038.(5)

Another benefit was that the cost of malpractice insurance premiums began to level. In fact, some who switched carriers paid lower premiums.

The largest malpractice insurance company in Indiana in a letter to me dated January 26, 1983 updated some figures given to the Indiana Malpractice Study Commission on September 7, 1978.

Their annual incidence of claims of physicians in Indiana insured with them on the date the file was opened, not the date when services were rendered was:

1965	1 for every 92
1970	1 for every 53
1972	1 for every 25
1974	1 for every 17
1975	(1st half before law in effect) 1 for every 15
1975	(2nd half just after law in effect) 1 for every 17
1976	1 for every 20
1978	1 for every 20
1980	1 for every 18
1981	1 for every 15

Their legal victories including jury verdicts, directed verdicts, summary judgments and dismissals was:

1973	15% of claims closed
1975	31% of claims closed
1977	42% of claims closed
1978	37% of claims closed
1979	35% of claims closed
1980	43% of claims closed
1981	46% of claims closed

Settlements to include all cases settled for less than average cost of defense, irrespective of liability:

During 1973-74	29% of claims closed = 3.1% of dollars
During 1976-77	21% of claims closed = 2.8% of dollars
During 1979-80	22% of claims closed = 1.5% of dollars

Settlement of "severe damage cases" to include all claims with payments from all defendants of $10,000 or more:

During 1973-74	25% of paid claims = 80% of dollars
During 1976-77	24% of paid claims = 85% of dollars
During 1979-80	45% of paid claims = 95% of dollars

The dollars paid are for loss only and does not include legal costs.

The average losses of the 10 most costly Indiana claims were:

Closed during 24 month period of 1965-66	$ 10,435
Closed during 24 month period of 1969-70	24,850
Closed during 24 month period of 1973-74	108,400
Closed during 24 month period of 1975-76	242,200
Closed during 24 month period of 1977-78	312,550
Closed during 24 month period of 1979-80	169,250

This dramatic reduction for 1979-80 possibly may be due to the fact that the company did not always know the ultimate amount paid from the Patients' Compensation Fund so the realistic total figure could be some higher.

Of the new claims filed in 1981 only 3.5% involved services rendered prior to enactment of the 1975 law indicating that the bulk of the claims now filed are covered under the present Indiana Malpractice Act.

The author of the letter to me giving the updated figures said: "Our general position is that we remain very optimistic in regard to the effect of the Indiana Malpractice Act, even though we have not been able to achieve a long range reduction in claims or in loss payments. However, in contrast with other states, it can be easily seen that Indiana is in a favorable position. This is evidenced by the attraction of other companies in the last year or so entering the professional liability field in the state."

As of January 1, 1983 there were 25,753 admitted Health Care Providers with 8038 of them being physicians, 2404 dentists, 12,645 nurses, 127 hospitals, and 2,539 miscelloneous.(5)

There were 2,138 complaints filed with the Department of Insurance since July 1, 1975 the effective date of the law; of this number 477 requested

Chart 1

PATIENTS COMPENSATION DIVISION

STATUS OF COMPLAINTS FILED PER YEAR AS OF DECEMBER 31, 1982

YEAR	NUMBER OF COMPLAINTS FILED PER YEAR	COMPLAINTS PENDING (a)	COMPLAINTS PROGRESSING (b)	PROBLEM STATUS (c)	CLOSED (d)	PANEL OPINIONS (e)
1975	1	0	0	0	1	0
1976	18	1	2	0	7	8
1977	142	3	8	4	75	52
1978	272	14	28	2	142	86
1979	319	16	31	11	152	109
1980	401	52	92	22	146	89
1981	431	129	154	18	94	36
1982	554	325	164	20	38	7
CUMM TOTAL	2,138	540	479	77	655	387

(a) (b) (c) - Current active cases filed with the Patients' Compensation Division

(a) PENDING - complaint has been filed, but a request for a medical review panel has not yet been received.

(b) PROGRESSING - complaint has been filed, and a request for a medical review panel has been received. The file will remain in this stage until all members of a panel have been selected.

(c) PROBLEMS - complaint has been filed, but either a dollar amount has been referred to in the prayer, or the health care provider did not comply with the Malpractice Act, or a possible statute of limitations problem.

(d) CLOSED - complaint was filed, but it was closed prior to the rendering of a panel opinion.

(e) PANEL OPINION - complaint was filed and a medical review panel rendered an opinion.

the formation of a review panel; 541 have not requested a review panel; 387 panel opinions were rendered; 652 cases were settled prior to rendering of a panel opinion; and 78 are classified as "problem status." Chart 1 shows the breakdown of the above figures for each year since the effective date of the law.(5)

A total of $17,802,835.98 was collected as surcharge and deposited in the Patients' Compensation Fund. It earned $4,583,993.73 in interest for a total of $22,386,829.71; a total of $16,386,713.70 has been paid out in judgments leaving a balance of $6,000,116.01 which after office expenses for the 7 year period are subtracted becomes a balance of just under $5,700,000.(5)

Fifty three payments have been made from the Patient's Compensation Fund since its inception. Of the 53, 19 had panel opinions rendered: 34 were settled prior to rendering a panel opinion.(5)

There are 147 physicians with a total of 3 or more malpractice complaints; of the 147, 86 have 3, 38 have 4, 12 have 5, 5 have 6, 3 have 7, 2 have 8 and 1 has 9. There are 6 dentists with 3 or more malpractice complaints.(5)

There are 59 hospitals with 5 or more complaints with one hospital having 88, one with 56, one with 48, one with 45, one with 39, one with 26 and on down to 8 with 5.(5)

The year end report of 1981 showed 4 osteopaths and one chiropractor with 3 or more malpractice complaints.

The charges for physicians malpractice insurance premiums by classification for Indiana by the largest insurer in the state is shown in Chart 2 below. The charges are 1983 rates and include the 25% surcharge.

Chart 2

MEDICAL
PROFESSIONAL LIABILITY INSURANCE RATES

Including Indiana Patients' Compensation Fund Surcharge

LIMITS	CLASS I	CLASS II	CLASS III	CLASS IV	CLASS V	CLASS VI	CLASS VII
$100,000/$300,000	$659	$1098	$1927	$3323	$4521	$4792	$5271
Patients' Compensation Fund Surcharge	$165	$ 275	$ 482	$ 831	$1130	$1198	$1318
TOTAL	$824	$1373	$2409	$4154	$5651	$5990	$6589

Partnership or corporation coverage is provided by separate policy.

Doctors entering their first year of practice following completion of a medical training program may be eligible for first year (50%) and second year (30%) discounts.

Comparative charges with some other states are shown in Chart 3 below.

Chart 3

COMPARATIVE RATES AS OF 1/1/83
Limits of $1 million/$1 million or Indiana Cap.

Rates of The Medical Protective Company used for all states except Florida and New York. For Florida and New York, rates shown are for Medical Society sponsored insurers.

None of the states listed, except INDIANA, limits the liability of the doctor. All rates are for occurrence policies except Florida, where the mature claims-made rate is shown.

Florida has a state compensation fund, as does Indiana.

	High	Low
Class I	New York Metropolitan $4936.00	Indiana $ 824.00
Class II	Florida Metropolitan $8,449.00	Indiana $1373.00
Class III	Florida Metropolitan $13,187.00	Indiana $2,409.00
Class V	Illinois Metropolitan $28,554.00	Indiana $5,651.00
Class VI	Florida Metropolitan $30,439.00	Indiana $5,990.00
Class VII	Florida Metropolitan $35,006.00	Indiana $6,589.00

Other side effects, perhaps temporary, but nevertheless good while they last are that the public is more knowledgeable about the problem, and there has been more rapport and open discussion between the doctor and his patients about their care. Those who cut back on services and were talking of closing their offices returned to their normal activities; further Dean Beering said, "The law is attracting out-of-staters who formerly had no intention of practicing there."(4) Medical groups find recruitment of new physicians easier.

Plaintiff attorney F. Boyd Hovde, then Legislative Chairman of the Indiana Trial Lawyers Association said: "Lawyers as well as doctors have a stake in a law that keeps liability insurance alive. It stands to reason that a trial lawyer would rather be able to get as much as half a million dollars for a client than tell the client he can't collect because the doctor has no insurance."(4)

VII. QUESTIONS CONCERNING NEED FOR FURTHER CHANGES

With such a far reaching law there are bound to be questions raised. Many of the flaws and some of the objectives have been corrected by amendments. There still remain some questions. Even though I admit to being prejudiced in favor of the law I want to raise them. Does the panel take away patient's rights? Are the limits too low? Is the time limit too short? Should the time for bringing a suit be after the time of discovery rather than after the occurrence? Should attorney's fees be limited? Since physicians make up the panel, is that like sending the fox to watch the chicken coop? By insulating physicians from some suits, could it breed medical carelessness?

Another question that has been raised is: Does the State Insurance Commissioner have adequate means to protect the Patient's Medical Compensation Fund? The statute creates no duty on the liability insurer to defend the fund if a health care provider or liability insurer agrees to settle for an amount over $100,000.(6)

The Insurance Commissioner lacks a method of tracking and obtaining the disposition of settlements or cases pending.(6)

There is also the question of disciplinary action against those health care providers who have been found guilty of malpractice. As of March, 1982 there had been but one physician disciplined.(6)

VIII. CONCLUSION

Based on results and findings thus far the Indiana Malpractice Law is not doing all that the most euphoric backers first thought it would and still think it should. But, its positive aspects, as far as insurance availability at reasonable costs, keeping physicians in practice, emergency room doors open, anesthetists staying on the job, and needed high risk surgery being done, seem to outweigh the negative aspects.

Malpractice problems differ from state to state depending on many factors. For that reason it should be addressed by a one on one state by state attack. A federal malpractice effort would require a congressional bulldozer where perhaps a sensitive state hand is all that's required. Every health care provider, every lawyer, every insurance company and above all every American deserves our best shot at the problem.

FOOTNOTES

1. Information, except as indicated in the body of the article, was gleaned from personal notes and addresses from 1974 to 1982.

2. Legislative history obtained from House And Senate Journals, 1975.

3. Statement at Interium Malpractice Study Committee, Sept. 14, 1982 as reported in memorandum to Don Foy, Indiana State Medical Association Executive Director, by a member of his staff, Bob Sullivan, Sept. 17, 1982.

4. Ferber, Stanley, Senior Editor, "Indiana Malpractice Law: The Results So Far," Medical Examiner, Medical Economics, March 22, 1976.

5. 1982 Year End Report, Patient's Compensation Division, Indiana Department of Insurance.

6. King, Richard R., Legal Counsel; Indiana State Medical Association Ad Hoc Malpractice Committee Report, March 23, 1982.

STATE of INDIANA

HARRY E. EAKIN, Commissioner
THE DEPARTMENT OF INSURANCE
309 STATE OFFICE BUILDING

INDIANAPOLIS, 46204

ROBERT D. ORR
Governor

August 6, 1986

Dr. Otis R. Bowen
1250 South Washington Street
Alexandria, VA 22314.

Dear Dr. Bowen:

This letter is a follow-up to our conversation this morning concerning the Patients' Compensation Fund and the medical malpractice in the State of Indiana.

The plan is still working essentially the same way as it did when you were our leader; i.e., the medical provider provides the first $100,000 and the Patients' Compensation bases any liability between $100,000 and $500,000. There have been a few changes during the years that allows the Commissioner to raise the surcharge to 100%, which is the current percentage rate. We can now pay out twice a year in June and December, rather than once a year as it was before. Another important change has been for the Fund to settle with structured settlements rather than a lump sum, and that is just starting to work and work well. In my opinion, this is a better settlement for the plaintiff, as well as saving the Fund some money.

I expect to ask for some legislation in 1987 to make it mandatory that all settlements for pain and suffering, loss of income and other items of this nature, be settled on a structure rather than cash. I have enclosed a newspaper article which is typical of what happens when you pay the plaintiff in cash. I will also ask the Legislature to remove the cap on the surcharge so that we can raise it when necessary.

I have also enclosed some rates for medical malpractice in Indiana and surrounding states by The Medical Protective Company and the St. Paul national rates. In addition, I have enclosed "crude" graphs to give you some idea of the plans since its inception.

You can tell Congress that we think Indiana is the model of the United States, and we get inquiries from other states almost on a weekly basis, as to how our program is working. Should you need further information, please feel free to contact me.

Sincerely,

Harry

Harry E. Eakin
Commissioner

HEE/jt

Enclosures

Administrative Services, (317) 232-2385
Agency Services, (317) 232-2389
Company Services, (317) 232-2397
Consumer Services, (317) 232-2395
Financial Services (317) 232-2390

July 1, 1986

The Medical Protective Insurance Company
Fort Wayne, Indiana

Lowest Rated Area
100/300 LIMITS

Class	Indiana	Illinois	Michigan	Ohio	Kentucky
1	823	2,720	4,881	1,478	1,238
2	1,564	5,168	9,274	2,808	2,352
3	2,058	6,800	12,203	3,695	3,095
4	2,469	8,160	14,643	4,434	3,714
5	4,773	15,776	28,310	8,572	7,180
6	5,679	18,768	33,679	10,198	8,542
7	6,584	21,760	39,048	11,824	9,904
8	6,996	24,480	43,929	12,563	11,142

Higest Rated Area
100/300 LIMITS

Class	Indiana	Illinois	Michigan	Ohio	Kentucky
1	992	4,129	7,953	1,838	
2	1,885	7,845	15,111	3,492	
3	2,480	10,323	19,883	4,595	
4	2,976	12,387	23,859	5,514	
5	5,754	23,948	46,127	10,660	
6	6,845	28,490	54,876	12,682	
7	7,936	33,032	63,624	14,704	
8	8,432	37,161	71,577	15,623	

NEWS 4/24/86

FRANKLIN, Ind. — A great blue heron returns to its nest in a Johnson County rookery. There are 51 blue heron rookeries in Indiana, according to the Department of Natural Resources. The Johnson County rookery contains 142 nests. The state's largest colony is in Steuben County and contains 367 nests. Story, other pictures on Page 17. — The NEWS Photo, Jim Young.

Pair allegedly 'looted' son's award

The Associated Press

CROWN POINT, Ind. — The parents of a 10-year-old quadriplegic boy awarded $500,000 in a medical malpractice settlement face felony charges because prosecutors contend they looted more than half the money.

All that remains of the settlement is $39.50, Lake County Prosecutor Jack Crawford said Wednesday.

Lottie and Fred Dozier are accused of one count each of felony theft of more than $100,000, and the father is charged with one count of perjury on charges of falsifying reports to the court on how the money was spent.

The felony theft charges were filed Wednesday.

Crawford said the Doziers were appointed guardians of their son in 1980 to administer the court settlement. The boy suffered brain damage and spinal meningitis at birth.

The settlement netted $500,000 and the Doziers spent $245,000 with court approval on their son, but misused the remaining $255,000, Crawford said.

Crawford said that the couple wrongly spent $35,000 on restaurants and entertainment, $15,000 on a new Cadillac, $6,000 on ocean cruises, $5,000 on gambling in Las Vegas, $2,800 on country club dues and $60,000 on miscellaneous items.

"I've been the prosecutor here for eight years, and I've never seen charges like this, where parents have stolen their son's savings, his life proceeds," Crawford said.

He said the court allowed the Doziers to buy a new $70,000 home and install a swimming pool. In addition, they were allowed to keep $12,000 a year for "administrative expenses," Crawford said.

Update

Medical Liability Insurance Rate Comparisons

Average medical liability insurance premiums for St. Paul insured physicians and surgeons before the proposed July 1, 1986, rate increases ranged from $3,568 in Arkansas to $29,720 in the metro Miami (Florida) area.

If the St. Paul's proposed rates are implemented, average premiums will range from $5,610 in Arkansas to $39,258 in the metro Los Angeles area (see map).

These average premiums are based on Class IV doctor rates, primarily for liability limits of $1 million/$3 million.

The St. Paul defines a Class IV doctor as a family or general practitioner who performs major surgery and an emergency medicine physician who doesn't perform major surgery. Class IV doctor rates reflect the average premiums charged for all physicians and surgeons insured by The St. Paul.

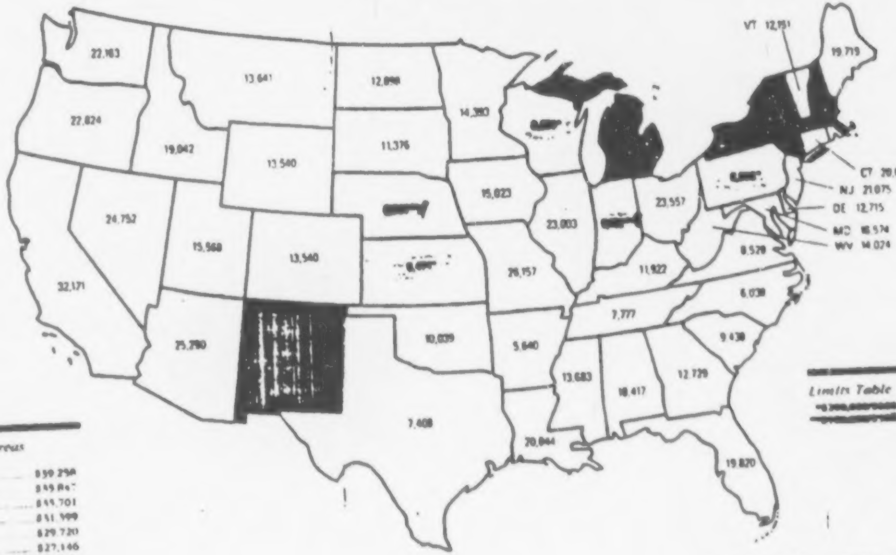
Proposed Rates

■ The map shows the proposed average rates for $1 million/$3 million limits of liability across the country (except in states where mandatory Patient Compensation Funds exist). These are reflective of the rate increases The St. Paul has recently filed for.

Individual premiums are not only affected by the state in which the physician practices but also the limits of liability selected, the number of claims-made coverage years and his or her specialty.

St. Paul Fire and Marine Insurance Company Proposed Physician & Surgeon Average Rates After July 1, 1986

(Class IV doctor/mature claims-made rates primarily at $1 million/$3 million limits)


22,103
22,824
32,171
24,752
19,042
13,641
13,540
15,560
13,540
25,790
12,898
11,376
10,039
7,408
14,393
15,023
26,157
5,640
20,044
23,003
13,683
10,417
12,729
19,820
7,777
11,922
23,557
8,529
6,039
9,438
VT 12,151
19,719
CT 20,630
NJ 21,075
DE 12,715
MD 18,574
WV 14,024

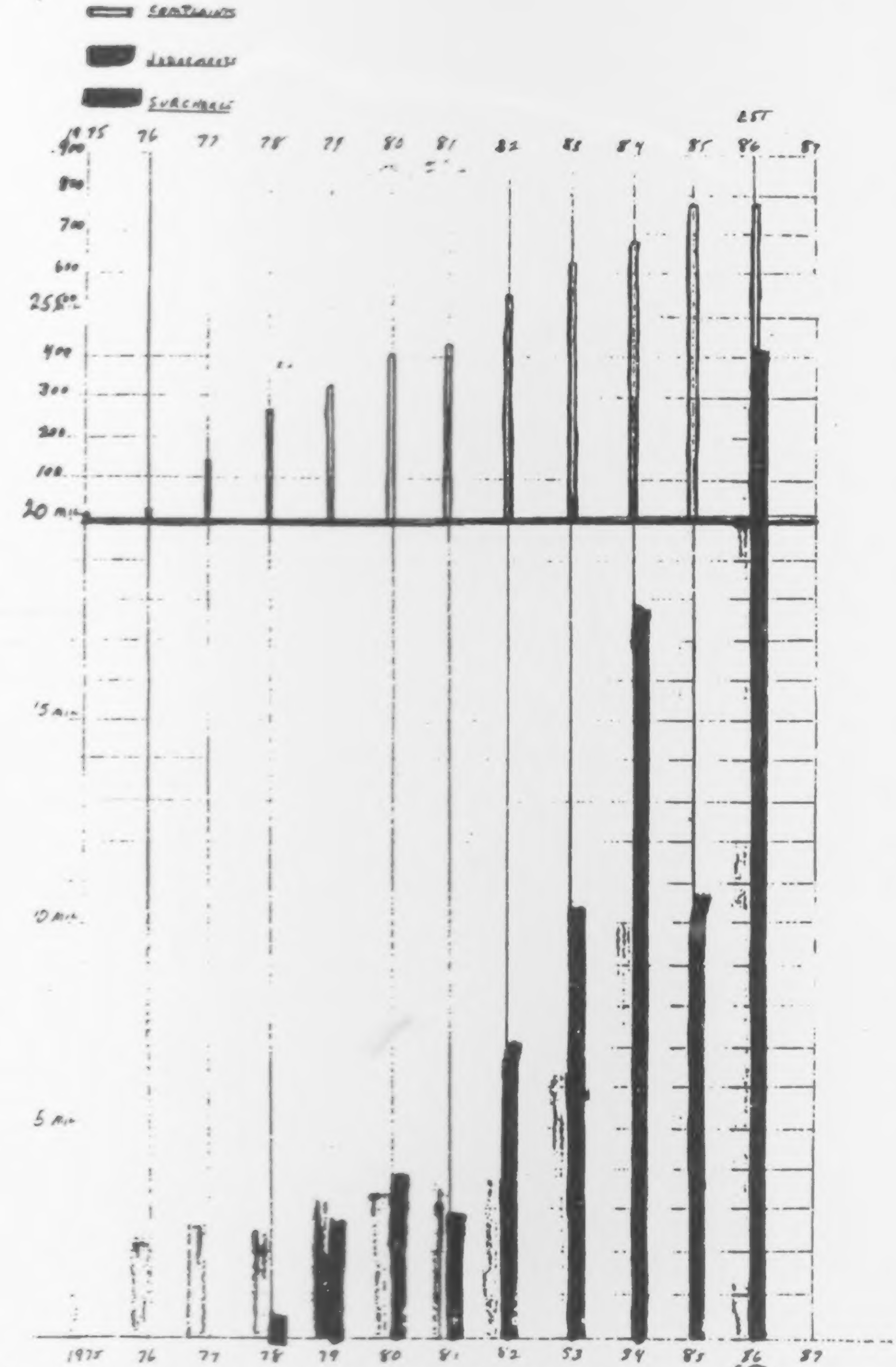
■ The St. Paul does not offer physicians and surgeons medical liability insurance in these states

Major Metro Areas

Los Angeles	$39,298
Chicago	$35,867
San Francisco	$35,701
St. Louis	$31,999
Miami	$29,720
Stamford	$27,146
New Orleans	$25,099
Washington D.C.	$20,564
[redacted]	

Limits Table

[redacted]


COMPLAINTS
JUDGEMENTS
SURCHARGE
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EST
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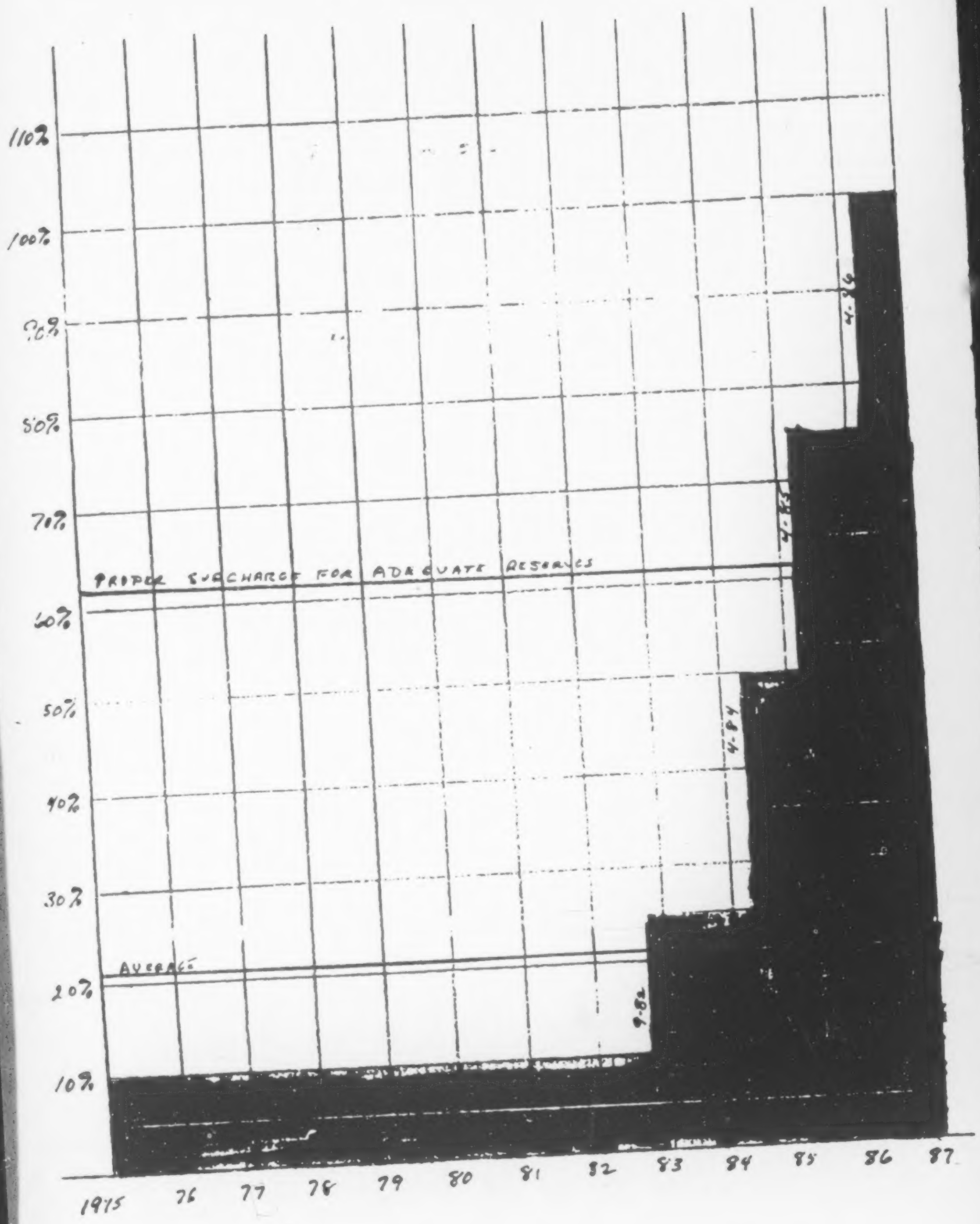
110%
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PROPER SURCHARGE FOR ADEQUATE RESERVES
AVERAGE
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Actuarial Analysis of the Indiana Patients Compensation Fund

The purpose of this study is to analyze the adequacy of the present seventy-five percent surcharge should it be used in 1986.

From the beginning of the Fund in 1975, through August 1982, the surcharge on malpractice premiums paid by Health Providers was ten percent. This surcharge beginning September 1, 1982, was increased to twenty-five percent. Beginning April, 1984, it was increased to fifty percent; and in April, 1985 was increased to the present seventy-five percent.

The average surcharge from the beginning through 1985 is about twenty-one percent.

The calculation of the present needed surcharge is presented with the aid of the attached Exhibits. Exhibit One shows the pattern of incurred loss payments according to the annual statement of the Medical Protective Company, Fort Wayne, Indiana.

Exhibit Two shows the actual dollars of surcharge collected since 1975. In order to measure the adequacy of the seventy-five percent surcharge, it is necessary to determine what the dollar surcharges would have been had the present seventy-five percent surcharge been in effect since 1975.

Exhibit Three shows the calculation of interest earnings of 12.5 percent.

Exhibit Four shows the calculation of total incurred losses from 1975 through 1984. Total payments were determined through the Judgment Entry data, as of December 31, 1985 by the year in which the malpractice occurred. Factors from Exhibit One were used to convert incurred paid losses to total incurred losses.

With the above Exhibits, it is possible to make the calculation shown in Exhibit A. It will be noted from Exhibit A that the calculation was made as of December 31, 1984. This is because no losses were paid in 1985 where the malpractice occurred in 1985 which would give an unrealistic zero value for malpractice claims occurring in 1985.

Exhibit A indicates a surcharge of 62.0% for 1975-1984.

The $11,715,001 of claims paid in 1985 was significantly less than the $17,734,930 for 1984. The 1986 payments could possibly revert to the 1984 level.

Exhibit Five shows a "Consolidated Fund Statement" for 1975 through 1985. From (Line 5) of Exhibit Five it shows that, considering surcharge collected (Line 1), interest earned (Line 2), expenses paid (Line 3), claims paid (Line 4), that the Fund would have had a negative balance of $1,342,921 as of December 31, 1985. The thing that has produced a positive balance as of December 31, 1985, (Line 7), is the $7,214,113 (Line 6) that was transferred from the "Indiana Residual Malpractice Insurance Authority". As Exhibit Five shows, the surcharges have just about been sufficient to operate the "Fund" on a "pay as you go" basis.

Should this plan be terminated, providing for no further surcharges but for future payments of malpractice occurring before 1985, there would be an estimated $90 million of unfunded liability. In order to provide for some reserve build up for this unfunded liability, it is recommended that this seventy-five percent surcharge be increased to one hundred percent for 1986.

Respectfully submitted,

J. Edward Faust, FCAS-MAAA

Exhibit A

Incurred Losses 1975-1984

Item		Amount
1.	1975-1984 surcharges at 75% level (Exhibit 2)	$159,880,644
2.	Interest rates (Exhibit 3)	12.5%
3.	Total income = (1) x [1+(2)]	178,865,725
4.	Expenses 1975-1984	464,247
5.	Net income at 75% surcharge = (3)-(4)	178,401,478
6.	Incurred loss estimate 1975-1984 (Exhibit 4)	147,402,595
7.	Indicated surcharge = 75% x (6) ÷ (5)	62.0%

Exhibit 1

Medical Protective - Schedule P - Part 3 Loss Development

Calendar Year	Percent of Incurred Losses Paid Through Indicated year 1	2	3	4	5
1976	1.5%	6.2%	12.3%	23.1%	35.4%
1977	2.9	5.9	11.8	22.1	35.3
1978	2.7	5.5	12.3	23.3	38.4
1979	1.4	4.1	12.3	26.0	--
1980	2.6	6.4	14.1	--	--
1981	2.3	5.8	--	--	--
1982	2.1	--	--	--	--
Year	2.2%	5.7%	12.6%	23.6%	36.4%

Values for the 6th through the 11th year were extrapolated from the above values with the following results.

Development	Accumulated Percent of Incurred Losses Paid
1	2.2%
2	5.7
3	12.6
4	23.6
5	36.4
6	52.3
7	71.3
8	93.4
9	96.7
10	98.4
11	100.0

Exhibit 2

Surcharges Adjusted to Current Level

1.	1975 through 1981 surcharges at 10% level =	$ 15,048,645
2.	= (1) at 25% level	37,621,612
3.	1982 surcharges - 10% for 8 months and 25% for 4 months =	2,754,189
4.	1982 surcharges at 25% level = $\frac{300}{180}$ x (3)	4,590,315
5.	1983 surcharges at 25% level	5,627,314
6.	1984 surcharges 25% for 3 months - 50% for 9 months	9,545,038
7.	1984 surcharges at 50% level = (6) x $\frac{600}{525}$	10,908,614
8.	1975 - 1983 surcharges at 25% level = (2)+(4)+(5)	47,839,241
9.	1975 - 1983 surcharges at 50% level = 2 x (8)	95,678,482
10.	1975 - 1984 surcharges at 50% level = (7) + (9)	106,587,096
11.	1975 - 1984 surcharges at 75% level = $\frac{75}{50}$ x (10)	159,880,644
12.	Actual surcharges collected 1975 - 1984	32,975,188
13.	Actual surcharges collected in 1985	16,449,210
14.	Actual surcharges collected 1975 - 1985 = (12)+(13)	49,424,398

STATUS OF MEDICAL MALPRACTICE COMPLAINTS FILED WITH THE DEPARTMENT OF INSURANCE

CUMMULATIVE TOTAL SINCE JULY 1, 1975 TO DECEMBER 31, 1985

	1.	Total number of complaints filed with the Department of Insurance since July 1, 1975:			4,225
	2.	Current number of active cases which have requested the formation of a medical review panel:		870	
	3.	Current number of active cases which have not yet requested the formation of a medical review panel:		973	
	4.	Current number of cases in which a panel opinion has been rendered:		910	
	5.	Current number of cases which were settled prior to the rendering of a panel opinion:		1,171	
	6.	Current number of cases which were settled after a panel opinion was rendered:		46	
	7.	Current number of cases which are presently defined as "Problem Status":		76	
	8.	Current number of cases which judgements have been paid:		179	
*	9.	Current number of cases which have selected all 4 panel members:	292		
*	10.	Current number of cases which have requested a panel but all members have not yet been selected:	578		
		11. TOTALS:	870	4225	4225

* This figure is reflected in No. 2 above.

One hundred Seventy-nine (179) payments have been made from the Patients Compensation Fund since its inception. Of this total figure, Sixty-nine (69) cases have had panel opinions rendered, the remaining one hundred ten (110) cases were settled prior to the rendering of a panel opinion.

Exhibit 3
Interest Earnings

Item	Amount
1. Surcharges collected 1975 - 1983	$ 23,430,149
2. Surcharges collected 1984	9,545,038
3. Surcharges collected 1985	16,449,210
4. Surcharges collected 1975 - 1985 = (1)+(2)+(3)	49,424,397
5. Interest Earned 1975 - 1983	5,248,313
6. Interest Earned 1984	461,977
7. Interest Earned 1985	549,070
8. Interest Earned 1975 - 1985 = (5) +(6)+(7)	6,259,360
9. Interest rate = (8) ÷ (4) x 100%	12.5%

Exhibit 4

Development of Incurred Losses

Incurred Year	(1) Payments through 12/31/84	(2) Factors	(3) Developed Incurred Losses =(1)÷(2)
1975	$ 2,125,000	100.0%	$ 2,125,000
1976	2,767,500	98.4	2,812,500
1977	8,240,714	96.7	8,521,938
1978	8,450,000	93.4	9,047,109
1979	6,885,603	71.3	9,657,227
1980	8,146,500	52.3	15,576,481
1981	8,521,042	36.4	23,409,456
1982	5,838,575	23.6	24,739,725
1983	4,567,500	12.6	36,250,000
1984	870,000	5.7	15,263,158
1985	-0-	2.2	-
Totals	$56,412,434	xx	$ 147,402,595

Claims paid in 1984 -	$ 17,734,930
Claims paid in 1985 -	$ 11,719,220

Exhibit 5

Consolidated Fund Statement 1975-1985

1.	Surcharge collected 1975 - 1985	$49,424,398
2.	Interest earned 1975 - 1985	6,259,360
3.	Expenses paid 1975 - 1985	618,464
4.	Claims paid 1975 - 1985	56,408,215
5.	Net income = (1) + (2) - (3) - (4)	(1,342,921)
6.	Transfer from IRMIA	7,214,113
7.	Balance 12/31/85 = (5) + (6)	5,871,192

PATIENTS COMPENSATION DIVISION

STATUS OF COMPLAINTS FILED PER YEAR AS OF DECEMBER 31, 1985

YEAR	NUMBER OF COMPLAINTS FILED PER YEAR	COMPLAINTS PENDING (a)	COMPLAINTS PROGRESSING (b)	PROBLEM STATUS (c)	CLOSED (d)	PANEL OPINIONS (e)	CLOSED PANEL OPINIONS (f)	JUDGEMENTS PAID (g)
1975	1	0	0	0	1	0	0	0
1976	18	0	2	0	8	7	1	0
1977	141	3	3	4	71	46	4	10
1978	272	9	9	2	146	81	14	11
1979	319	6	13	9	152	104	5	30
1980	401	22	37	19	181	110	7	25
1981	431	32	80	14	163	122	1	19
1982	556	51	117	13	177	151	8	39
1983	628	90	155	14	140	196	6	27
1984	684	219	255	0	104	92	0	15
1985	773	541	199	1	28	1	0	3
CUMM. TOTAL	4225	973	870	76	1171	910	46	179

(a) (b) (c) - Current active cases filed with the Patients Compensation Division.

(a) PENDING - Complaint has been filed, but a request for a medical review panel has not yet been received.

(b) PROGRESSING - Complaint has been filed, and a request for a medical review panel has been received. The file will remain in this stage until all members of a panel have been selected.

(c) PROBLEMS - Complaint has been filed, but either a dollar amount has been referred to in the prayer, or the health care provider did not comply with the Malpractice Act, or a possible statute of limitations problem.

(d) CLOSED - Complaint was filed, but it was closed prior to the rendering of a panel opinion.

(e) PANEL OPINION - Complaint was filed and a medical review panel rendered an opinion.

(f) CLOSED PANEL OPINION - Complaint was filed and a medical review panel rendered an opinion, complainr was closed.

(g) JUDGEMENTS PAID - Complaint was filed, Judgement paid from the Patient's Compensation Fund.

MEDICAL MALPRACTICE PANEL OPINIONS

Total Panel Opinions rendered since the inception of the Malpractice Act: 1,025

Panel Opinions rendered in 1985: 276
Malpractice: 24
No Malpractice: 217
Material Issue of Fact: 10
Variations: 25

Panel Opinions rendered in 1984: 205
Malpracitce: 20
No Malpracitce: 144
Material Issue of Fact: 11
Variations: 30

Panel Opinions rendered in 1983: 173
Malpractice: 21
No Malpractice: 133
Material Issue of Fact: 6
Variations: 13

Panel Opinions rendered in 1982: 123
Malpractice: 25
No Malpracitce: 85
Material Issue of Fact: 6
Variations: 7

Panel Opinions rendered in 1981: 118
Malpractice: 16
No Malpracitce: 94
Material Issue of Fact: 4
Variations: 4

Panel Opinions rendered in 1980: 69
Malpractice: 7
No Malpractice: 55
Material Issue of Fact: 1
Variations: 6

Panel Opinions rendered in 1979: 40
Malpractice: 6
No Malpractice: 33
Material Issue of Fact: 1

Panel Opinions rendered in 1978: 17
Malpractice: 3
No Malpractice: 13
Material Issue of Fact: 1

Panel Opinions rendered in 1977: 3
Malpractice: 1
No Malpractice: 2

Panel Opinions rendered in 1976: 1
Malpractice: 1

Panel Opinions rendered in 1975: 0

CALENDER YEAR STATISTICS FOR THE PATIENTS COMPENSATION FUND

THROUGH DECEMBER 31, 1985

	1975	1976	1977	1978
Surcharge Collected	$975,708.59	$2,294,261.00	$2,402,310.45	$2,306,934.32
Interest Earned	0	25,500.00	207,831.93	265,657.40
Sub-Total	975,708.59	2,319,761.00	2,610,142.38	2,572,591.72
Judgements Paid	0	0	0	-425,000.00
TOTAL	$975,708.59	$2,319,761.00	$2,610,142.38	$2,147,591.72

	1979	1980	1981	1982
Surcharge Collected	$2,306,546.58	$2,426,958.83	$2,335,927.65	$2,754,188.56
Interest Earned	836,941.21	824,596.54	1,358,172.55	1,065,294.10
Sub-Total	3,143,487.79	3,251,555.37	3,694,100.20	3,819,482.66
Judgements Paid	-2,894,500.00	-3,900,000.00	-1,972,500.00	-7,194,713.70
TOTAL	$ 248,987.79	$ (648,444.63)	$1,721,600.20	$(3,375,231.04)

	1983	1984	1985	TOTAL
Surcharge Collected	$5,627,314.35	$9,545,038.08	$16,449,209.80	49,424,398.21
Misc. Revenue I.R.M.I.A		7,214,113.00	-0-	7,214,113.00
Interest Earned	664,318.64	461,976.57	549,070.08	6,259,359.02
Sub-Total	6,291,632.99	17,221,127.65	16,998,279.88	62,897,870.23
Judgements Paid	-10,571,570.00	-17,734,930.00	-11,715,001.37	-56,408,215.07
TOTAL	$(4,279,937.01)	(513,802.35)	5,283,278.51	6,489,655.16

		$6,489,655.16
Administrative Expenses July 1, 19~~8~~75 through December 31, 1984	464,246.54	
Administrative Expenses January 31, 1985 through December 31, 1985	154,217.46	-618,464.00
Fund Balance as of December 31, 1985		5,871,191.16

---

* Judgements are paid from the Patient's Compensation Fund once a year between January 1st and 15th of the year following settlement.

MULTIPLE CLAIMS REPORTS

DECEMBER 31, 1985

Total Number of Physicians with two or more complaints filed against them: 1003

614 Physicians have 2 malpractice complaints filed against them.

214 Physicians have 3 malpractice complaints filed against them.

79 Physicians have 4 malpractice complaints filed against them.

41 Physicians have 5 malpractice complaints filed against them.

27 Physicians have 6 malpractice complaints filed against them.

11 Physicians have 7 malpractice complaints filed against them.

5 Physicians have 8 malpractice complaints filed against them.

5 Physicians have 9 malpractice complaints filed against them.

4 Physicians have 10 malpractice complaints filed against him.

1 Physician has 11 malpractice complaints filed against him.

2 Physicians have 13 malpractice complaints filed against him.

Total Number of Dentists that have complaints filed against them: 217

166 Dentists have 1 malpractice complaint filed against them.

34 Dentists have 2 malpractice complaints filed against them.

7 Dentists have 3 malpractice complaints filed against them.

4 Dentists have 4 malpractice complaints filed against them.

6 Dentists have 5 malpractice complaints filed against them.

Total number of Hospitals with five or more complaints filed against them: 81

28 Hospitals have 5 to 10 malpractice complaints filed against them.

24 Hospitals have 11 to 20 malpractice complaints filed against them.

10 Hospitals have 21 to 30 malpractice complaints filed against them.

11 Hospitals have 31 to 40 malpractice complaints filed against them.

3 Hospitals have 41 to 50 malpractice complaints filed against them.

2 Hospitals have 51 to 100 malpractice complaints filed against them.

3 Hospitals have 101 to 149 malpractice complaints filed against them.

SUMMARY OF 1986 MEDICAL MALPRACTICE AND TORT REFORM LAWS

Prepared by

Kathleen M. King

THE INTERGOVERNMENTAL HEALTH POLICY PROJECT
at
THE GEORGE WASHINGTON UNIVERSITY

September 29, 1986

MALPRACTICE

ALABAMA

H.B.202, Act 441, Laws 1986 Requires insurance companies which sell medical malpractice insurance to report judgments or settlements for personal injuries resulting from error, omission or negligence in the performance of professional services to appropriate state licensing agencies.

ALASKA

S.B.139, Chapter 139, Laws 2986 Specifies that damages for non-economic losses are limited to compensation for pain, suffering, inconvenience, physical impairment, disfigurement, loss of enjoyment of life and other nonpecuniary damages and cannot exceed $500,000 per claim. Exempts damages for disfigurement or severe physical impairment from this ceiling. Stipulates that punitive damages can not be awarded unless supported by clear and convincing evidence. Eliminates awards for damages resulting from felonious acts in cases where a felony conviction is obtained. Requires itemization of awards, with a differentiation between economic and noneconomic losses. Requires reduction of future economic awards to present value. Stipulates that awards be paid to the maximum extent feasible by periodic rather than lump sum payments. Provides limited immunity to members of the boards of nonprofit associations, school districts, or citizens' advisory committees of municipalities. Permits introduction of evidence of payments available to the plaintiff from specified collateral sources. Modifies the rule of joint and several liability. Specifies that defendants who are found to be liable for less than 50% of the total fault allocated to all defendants can not be held jointly liable for more than twice the percentage of fault allocated to them. Permits introduction of contributory fault and reduces compensation in awards in proportion to the plaintiff's contributory fault.

ARIZONA

H.B.2085, Chapter 379, Laws 1986 Requires plaintiffs' attorneys filing medical malpractice actions to file an affidavit with the health professions regulatory boards with a copy of the complaint and a report containing specified information about the claim. Directs the boards to initiate an investigation upon receipt of a report to determine whether a licensee is in violation of the statutes or rules governing licensure.

Note: The Arizona legislature passed H.B.2376, which would have limited contingency fees, permitted periodic payment of awards, required itemized verdicts, limited joint and several liability, and permitted introduction of evidence of payments from collateral sources. Governor Babbitt vetoed this bill.

H.B.2418, Chapter 367, Laws 1986 Permits the Director of Insurance to form a voluntary plan to provide medical malpractice liability insurance to licensed midwives and registered nurses certified as nurse-midwives if liability insurance is substantially unavailable through private insurers or the premiums being charged are so high that they threaten to cause a significant unavailability. Authorizes the director to form a joint underwriting association to provide insurance to midwives if he determines that a voluntary plan would fail to provide adequate coverage. If the director forms a joint underwriting association, all insurers are required to participate in it as a condition of transacting business in the state. Stipulates that the joint underwriting association is to offer insurance until June 30, 1988. Delineates the powers and duties of the joint underwriting association. Directs the Board of Directors to contract with an actuary to develop actuarily sound rates, but permits the board to offer rates that it determines are affordable, with deficits to be shared by all insurers in the state on a pro rata basis.

CALIFORNIA

INITIATIVE 51 Eliminates the doctrine of joint and several liability. Specifies that each defendant's responsibility is limited in direct proportion to his or her percentage of fault. (Note: This initiative was approved by the electorate in a June 3, 1986 election.)

S.B.2349, Chapter 247, Laws 1986 Extends until January 1, 1989 an existing requirement that a plaintiff's attorney file a certificate that stipulates that he or she has reviewed the facts of the case and has consulted with at least one other health care provider who believes the case has merit.

COLORADO

S.B.69 Check on the effects of the statue of limitations.

CONNECTICUT

H.B.6134, Public Act 86-338, Laws 1986 Limits attorneys' contingency fee arrangements to 33.3% of the first $300,000; 25% of the next $300,000; 20% of the next $300,000; 15% of the next $300,000; and 10% of any amount over $1.2 million. Provides for payment of settlements exceeding $200,000 on a periodic basis. Eliminates the rule of joint and several liability in negligence actions. Specifies that uncollectible damages are to be apportioned among solvent defendants in proportion to their share of fault. Previously, introduction of evidence regarding payment from collateral sources was permitted only for medical malpractice actions. This law permits collateral source evidence to be introduced in personal injury and wrongful death actions. Creates a rebuttable presumption that a person who sells alcoholic beverages to an intoxicated person before that person commits an act resulting in injury to another is liable for damages to the injured person. Prohibits the filing of a claim unless the attorney or person filing the claim has made a reasonable inquiry to determine that negligent acts were committed in the care or treatment of the plaintiff. Permits the court to require the payment of attorneys' fees and reasonable expenses to the prevailing party if it determines that the suit was not filed in good faith. Establishes a task force to study several civil liability and procedural issues including, but not limited to, a limitation on awards for noneconomic damages, codification of the law of punitive damages, periodic payment of judgments, encouragement of alternative dispute resolution procedures, regulation of attorney's fees, and codification of standards for expert witnesses.

DELAWARE

H.B.444, Chapter 264, Laws 1986 Authorizes the Insurance Commissioner to prohibit the cancellation or non-renewal of insurance policies pending a hearing in specified cases. Directs the commissioner to conduct hearings to determine whether lines of insurance are "critical" -- meaning that the type of coverage is generally unavailable at any price reasonably related to the risk and that the unavailability constitutes a risk to the public health, safety and welfare. Prescribes conditions under which critical lines of insurance may be cancelled or subject to nonrenewal. Stipulates amount of time within which policyholders must be notified of cancellation or nonrenewal of policies, and information that must be contained in such notices.

FLORIDA

S.B.465, 349, 592 698, 699, 700, 701, 702, 956, 977, and 1120, Chapter 86-160, Laws 1986 Imposes an immediate freeze in liability insurance rates and reduces rates by 40% to the end of calendar year 1986, which amounts to a 10% annual reduction in rates. Directs insurers to files new rates for 1987, with the underlying presumption that rates in effect January 1, 1984 will be considered adequate. Permits insurers to show cause why 1984 rates are inadequate, and directs the Insurance Department to take this testimony into account in setting rates. Permits the department to reject rates for reasons other than lack of competition and to order rate reductions. Imposes a cap of $450,000 on non-economic damages. Eliminates the collateral source rule. Modifies the rule of joint and several liability for awards in excess of $25,000 and allows for structured payments of awards upon request. Discourages frivolous lawsuits by directing the plaintiff to pay defendant's attorney fees in unfounded lawsuits. Limits punitive damages, in some cases, to three times the amount of compensatory damages, with 60% of damages to be paid to the Medical Assistance Trust Fund in cases of wrongful death and personal injury and to the general revenue fund in other cases.

H.B.1383, Chapter 86-287, Laws 1986 Limits risk management education requirements in health care facilities to nonphysician personnel. Requires arbitration panel to consider all relevant evidence and decide the issue of liability, amount of damages, and apportionment of responsibilities among the parties; does not permit arbitration panels to award punitive damages. Makes other changes in the duties and powers of arbitration panels. Stipulates that decisions of arbitration panels are not binding. Permits members of the Florida Patient's Compensation Fund to apply for deficit assessment coverage from the Joint Underwriting Association. Requires such coverage for the full amount of any deficit assessments up to twice the amount of the membership fee paid by the member during FY83.

GEORGIA

S.B.384 Requires insurers to submit information about direct writings for various lines of business, including medical malpractice. Stipulates that the information must include data concerning direct premiums written and earned; net investment income; net realized capital gains and losses; reserves information developed from a formula calculating reserves for reported and incurred claims and for incurred but not reported claims; net underwriting gain or loss, including net investment income.

H.B.1146 Establishes the conditions under which a judge can require a party who brings a frivolous suit to pay the other party's attorney's fees. Defines a frivolous lawsuit and authorizes a judge to decide if a case is frivolous and what attorneys' fees are to be awarded.

H.B. 1503 Requires insurers to notify consumers at least 45 days in advance of a cancellation, nonrenewal, an increase in rates of larger than 15%, except for those arising from changes in risk or exposure or a change in policy procedures which limit or reduce coverage. Insurers who fail to provide this notice must provide an additional 30 days of identical coverage at the same premium. Prohibits insurers from cancelling an entire line unless they prove to the Commissioner of Insurance that continuing the line would harm its policyholders or the public.

HAWAII

S.B. 51-X, Act 2, Laws 1986 Requires the Insurance Commissioner to impose a moratorium on commercial liability insurance rates from August 1, 1986 to September 30, 1986. Reduces liability insurance rates 10% from October 1, 1986 to September 30, 1986, 12% from October 1, 1987 to September 30, 1988, and 15% from October 1, 1988 to September 30, 1989, but excludes motor vehicle and medical malpractice liability insurance from these reductions. Stipulates that coverage under any policy of insurance is not construed to provide coverage for punitive or exemplary damages unless specifically included. Limits attorneys' fees in all tort actions to a reasonable amount, as approved by the court having jurisdiction. Permits both plaintiffs and defendants in tort actions in which a settlement is reached to request that attorneys' fees be subject to approval of the court having jurisdiction. In cases where the state or a political subdivision is liable for a judgement of more than $1 million, the state or political subdivision has the option of paying that portion of the award in excess of $1 million by periodic payments for a period not to exceed five years. Requires that periodic payment schedules be submitted to the court for final approval. Modifies the statute of limitations by requiring that actions by a minor must be commenced within six years of the date of the alleged wrongful act except that actions by a minor less than 10 years old must be commenced within six years or by the child's tenth birthday, whichever is longer. Permits the introduction of evidence of payments from collateral sources. Permits satisfaction of liens in settlements. Abolishes joint and several liability except under the following circumstances: for the recovery of economic damages involving death or injury; for the recovery of economic and noneconomic damages involving intentional torts, and specified other torts unrelated to medical malpractice; for the recovery of noneconomic damages in actions involving injury or death against defendants whose individual degree of negligence is 25% or more (in cases where a defendant's liability is less than 25%, the amount recoverable against that defendant is in direct proportion to the defendant's negligence); and in actions relating to certain types of automobile accidents. Limits awards in specified types of actions to $375,000 for pain and suffering. Abolishes serious emotional distress as a cause of action. Establishes a mandatory and nonbinding arbitration program, and requires that all cases having a probable jury award of $150,000 or less be submitted to the program. Appropriates $100,000 for subsidy payments covering liability insurance premiums of certain obstetricians and gynecologists.

ILLINOIS

Note: The Illinois Supreme Court issued a decision on June 20, 1986 that upheld four of five key provisions of a 1985 tort reform law. The court upheld structured verdicts, the abolition of punitive damages, a modified collateral source rule, and

limits on attorneys' fees. It struck down the use of pretrial screening panels on the grounds that they granted judicial authority to the nonjudicial members of the panel.

S.B.1200 Permits the court to award attorneys' fees to the prevailing party if it determines that the suit is frivolous or was brought for an improper purpose. Permits the imposition of similar sanctions on insurance companies for the same reason. Prohibits original complaints from including a demand for punitive damages. Permits requests for punitive damages to be added only after a hearing where the plaintiff establishes a reasonable likelihood of proof of acts that would support an award for punitive damages. Authorizes the court to distribute punitive damages among the plaintiff, his or her attorney, and the Department of Rehabilitative Services. Modifies joint and several liability for some types of actions, but excludes environmental and medical malpractice cases from the modification. Requires insurers to give 90 days notice of termination of any line of insurance, and requires the notice to include data supporting the decision.

INDIANA

S.B.393 Permits the court to award attorney's fees to the prevailing party if it finds that either party's claim was frivolous, unreasonable or groundless, or litigated in bad faith.

S.B.394 Permits the introduction of evidence of proof of collateral source payment with specified exceptions.

IOWA

S.B.2265 Prohibits payment for punitive or exemplary damages unless the conduct of the defendant constituted willful and wanton disregard for the rights or safety of another. Requires that part of punitive or exemplary damages awards be paid into a civil reparations trust fund in specified cases. Requires that a full and confidential report concerning a hospital disciplinary action that results in a limitation, suspension or revocation of a physician's privilege to practice medicine or any voluntary surrender or limitation of privileges related to professional competency be made to the board of medical examiners. Authorizes the court to requires parties commencing three or more unsuccessful tort actions within the last five years deemed frivolous by the court to stay proceedings until the party posts securities to pay the opposing party's costs, including reasonable attorneys' fees. Permits the court to approve structured, periodic, or other non-lump sum payments upon request. Establishes a commission to study: implementation of maximum caps on liability payments; elimination of the collateral source rule; a review of several facets of current insurance practices; alternative methods of litigating actions; alternative methods of litigating actions; alternatives to reduce nonmeritorious suits; and other topics. Directs the commission to report its findings to the legislative council by December 15, 1986.

KANSAS

H.B.2661 Requires medical care facilities to establish internal risk management programs. Requires health care providers or others directly involved in delivering of health care who know that a health care provider has committed an act which is or may constitute substandard care to report that information to the state or county professional association, the chief of the medical staff, or a state agency that licenses health care providers. Permits state licensing agencies that receive such reports to refer reports dealing with a provider's inability to practice with reasonable safety due to physical or mental disabilities, including deterioration through aging, loss of motor skill, or alcohol or drug abuse to an impaired provider committee of a state or county professional association. Authorizes the state licensing agency to enter into a contractual agreement with an impaired provider committee to provide treatment. Limits noneconomic damages to $250,000 and total awards to $1 million, including the $250,000 cap on noneconomic damages. Specifies that medical malpractice awards must be itemized to reflect amounts for economic and noneconomic losses. Prohibits qualification of a person as an expert witness unless at least 50% of the person's time within the preceding two year period has been devoted to actual clinical practice in the same profession in which the defendant is licensed. Requires insurers to report any claims or action for damages for medical malpractice to the state licensing agency and the Department of Insurance. Requires the court to hold a settlement conference not less than 30 days before trial. Directs the Insurance Commissioner to establish an experience rating system by rule to become effective on July 1, 1987. The system is to require a higher surcharge from health care providers based on past claims paid form the fund. Permits a licensing board to require proof of liability insurance coverage prior to renewal of a license, and revises the conditions under which the board may discipline a licensee.

LOUISIANA

S.B.719 Establishes a medical review panel within the Department of Administration to review all malpractice claims against the state or its agencies.

MAINE

S.B.958, Chapter 804, Public Laws 1986 Modifies the statute of limitations to state that the statute starts to run from the date of the act or omission giving rise to the injury and not from its discovery, except in specified cases. Requires that actions for professional negligence be commenced within three years after the cause of action accrues, except for minors. Requires that actions on behalf of minors begin within six years of the cause of action or within three years after the minor reaches maturity, whichever occurs first. Specifies that these filing restrictions do not apply to foreign objects left in human bodies. Requires professional licensing boards to treat information that a licensee has had three professional liability claims in the last ten years that have resulted in monetary judgments as a complaint against the licensee. Requires the boards to initiate a review in such cases. Establishes mandatory prelitigation screening and mediation panels: to identify claims of professional negligence which merit compensation; to encourage early resolution of those claims prior to commencement of a lawsuit; and to encourage early withdrawal or dismissal of nonmeritorious claims. Permits unanimous findings of the panel, both for and against the defendant and plaintiff, to be admissible in court proceedings; all other panel proceedings are to be kept confidential. If the panel finds unaminously that the defendant has been negligent or where there is reasonable medical or professional probability that the defendant's actions proximately caused the injury, the defendant is required to enter into negotiations to pay the claim or admit liability. If the panel unamiously finds that the defendant's actions were not negligent or did not proximately cause an injury, the plaintiff is required to release the claim or have the panels findings admitted in a subsequent court proceeding. Prohibits claims based upon wrongful life. Requires the court to approve periodic payment arrangements in settlements over $250,000 if either party requests it. Limits attorneys' contingency fees as follows: 33.3% of the first $100,000; 25% of the next $100,000; and 25% of any amount over $200,000. Requires the Commission to Examine Problems of Tort Litigation and Liability Insurance to examine medical and legal professional liability including statutes of limitation, discovery rules, contingent fees and caps on damage awards.

MARYLAND

S.B.558 Limits payment for noneconomic damages for personal injuries for actions commenced after July 1, 1986. Defines noneconomic damages as pain, suffering, inconvenience, physical impairment, disfigurement, loss of consortium or other nonpecuniary injury. Requires itemization of awards into the following catagories: past medical expenses; future medical expenses; past loss of earnings; future loss of earnings; noneconomic damages; and other damages. Permits periodic payment of awards. Directs insurers to submit specified information to the Insurance Commissioner about claims and reserves.

S.B.559, Chapter 640, Laws 1986 Makes changes in the jurisdiction of the Health Claims Arbitration Office and other changes in procedures followed by the panel.

S.B.560, Chapter 642, Laws 1986 Requires that copies of claims for damages due to medical injuries be sent to the Commission on Medical Discipline of Maryland and the Medical and Chirurigical Faculty of the State of Maryland. Requires the Faculty to inform the Commission on Medical Discipline about physicians against whom three or more malpractice claims have been filed within the last five years and directs the faculty to conduct an investigation. Requires the commission, in specified circumstances, to notify hospitals or other health care facilities where a physician has privileges that a complaint or report has been filed. Directs hospitals and other health care institutions to file reports about physicians practicing in their institutions every six months. Among other things, the report is to contain information about physicians who have had their privileges limited, reduced, or terminated for reasons that might be grounds for professional discipline. Requires hospitals, as a condition of licensure, to establish a credentialling process for physicians employed by or practicing at hospitals. Further requires hospitals to establish a risk management program as a condition of licensure.

MASSACHUSETTS

H.B.5700, Chapter 351, Laws 1986 Requires that rates paid providers of health care services by insurers and governmental units be adjusted, effective July 1987, for changes in medical malpractice insurance premium costs. Specifies that the total adjustments in payments to physicians should be sufficient to generate additional payments to physicians and dentists equal to the total dollar increase in medical malpractice premium charges. Delineates a formula for determining the adjustments. Establishes a medical malpractice analysis bureau in the Division of Insurance to analyze and collect data and advise the Commissioner of Insurance on requests filed by the joint underwriting association for changes in premiums and rates and other matters. Directs hospitals and health care institutions to inform the Board of

Registration in Medicine when a physician's staff privileges are restricted, revoked, not renewed, or when a physician's resignation is accepted for reasons related to competency to practice medicine or a complaint or allegation of a violation of a law or regulations. Requires the by-laws of hospitals and other health care facilities to contain provisions for reporting incompetent treatment or conduct that might be harmful to good patient care. Directs hospitals and nursing homes to participate in risk management programs as a condition of licensure. Establishes a disciplinary unit in the Board of Registration in Medicine with responsibility for investigating complaints and prosecuting disciplinary actions. Modifies the statute of limitations by requiring that actions be filed within three years from the date of the cause of action, except in the case of minors. Minors under the age of six are permitted to file actions until their ninth birthday, except that actions can not be commenced more than seven years after the occurrence of the act or omission of action. Exempts actions arising from foreign objects being left in bodies from these filing restrictions. Permits introduction of evidence regarding payment from collateral sources. Limits noneconomic awards to $500,000. Stipulates that attorneys' fees be fair and reasonable, and mandates that attorneys' fees not be granted if the disbursement to the plaintiff is less than past and future medical expenses, unless attorneys' fees are: 20% or less of the award; reduced to 20% or less of the award; or are reduced to a level which permits the plaintiff to pay past and future medical expenses. Establishes a commission on medical malpractice to study the legal, tax, reimbursement and regulatory status of nonprofit hospital service corporations and nonprofit medical service corporations. Directs the commission to investigate the feasibility of establishing a patient compensation fund and the viability of a system that would provide early compensation to victims of medical malpractice.

MICHIGAN

H.B.5154, Public Act 173, Laws 1986 Limits payment for noneconomic damages in medical malpractice actions to $225,000 unless one or more of the following conditions apply: there has been a death; there has been an intentional tort; a foreign object was wrongfully left in a person's body; the injury involves the reproductive system of the patient; the discovery of the existence of the claim was prevented by the fraudulent conduct of a health care provider; a limb or organ of the patient was wrongfully removed; or the patient has lost a vital bodily function. Requires the itemization of damages into economic and noneconomic damages. Specifies that the limit on noneconomic damages is to be increased each year to reflect the cumulative annual percentage increase in the consumer price index. Directs the court to review malpractice awards and set aside any noneconomic damages in excess of the limit. Permits the court to order a new trial in specified circumstances. Requires expert witnesses to be licensed physicians or dentists who specialize in the same specialty or a related area and who devote a substantial portion of their professional practice to actual clinical practice in the same or related specialty as the defendant. Directs the court evaluate the qualifications of expert witnesses. Authorizes the court to require the losing party to pay the winning party's costs and attorneys' fees if it determines that the suit is frivolous. Establishes a panel to mediate malpractice claims prior to trial and prescribes the powers and duties of the panel. Modifies the statute of limitations specifying that malpractice claims must be filed within six years after the date of the act or omission which is the basis of the claim. Grants exceptions to this limit in the following circumstances: if discovery of the claim was prevented by fraudulent conduct of a health care provider; if a foreign object was wrongfully left in a patient's body; or if the injury involves the reproductive system of the plaintiff. With regard to minors, stipulates that actions on behalf of minors thirteen years old or less must be commenced by the minor's fifteenth birthday. If the minor is more than thirteen years old at the time the act or omission occurs, the statute of limitations that applies to adults is in effect. Permits introduction of evidence regrading payments from collateral sources. Eliminates joint and several liability except in cases where one or more of the defendants is unable to pay his or her share of damages. Reallocates uncollectible judgments among defendants according to their proportionate share of fault, but exempts governmental agencies from this provision. Permits periodic payment of damages if both parties agree to it.

H.B.5209, Public Act 173, Laws 1986 Requires insurers providing professional liability insurance to submit information about claims filed for personal injury to the Department of Insurance. Directs that information about judgments, settlements or dismissal of claims be furnished to the appropriate licensing board and, if the insured is a hospital, to the Department of Public Health.

MINNESOTA

S.B.1612, Chapter 313, Laws 1986 Establishes a joint underwriting association to issue medical malpractice insurance to hospitals and nursing homes unable to obtain it in the voluntary market.

S.B.2078, Chapter 455, Laws 1986 Requires insurers to submit specified information to the Insurance Commissioner about premiums, claims, investment income, reserves, expenses, and operating gains or losses. Requires that affidavits be filed with malpractice claims which state that the plaintiff's attorney has reviewed the claim with an expert who thinks that the defendant deviated from acceptable standards of care. Permits introduction of evidence of payment from collateral sources in determining awards, but does not permit introduction of collateral source payments to juries. Permits the court to award payment of attorneys' fees to the prevailing party if it determines that the action was both frivolous and costly to the other party. Defines intangible loss as embarrassment, emotional distress and loss of consortium, but not including pain, disability or disfigurement. Limits awards for intangible loss to $400,000.

MISSOURI

S.B.663 Limits awards for noneconomic damages to $350,000 per defendant. Provides for adjustment to this limit to reflect increases in the cost of living. Narrows and clarifies the grounds for awarding punitive damages. Provides for itemization of awards. Permits periodic payment of future damages for awards over $100,000 upon request. Requires that an affidavit be filed with a suit for personal injuries. The affidavit must contain a statement from a physician certifying that there is merit to the case. Modifies the doctrine of joint and several liability with regard to health care providers. Specifies that defendants are jointly and severally liable for the amount of the award only with defendants who have equal or lesser liability. Directs the jury to apportion fault among defendants. Grants the Board of Healing Acts authority to make temporary, immediate suspensions of physicians' licenses. Requires the Department of Insurance to collect and submit information about medical malpractice claims to the board. Directs the board to review this information and take appropriate action. Requires physicians on hospital staffs in counties with populations over 75,000 to maintain at least $500,00 in medical malpractice insurance. Directs hospital boards of trustees to report disciplinary actions or restrictions taken against physicians to the appropriate licensing board.

NEW HAMPSHIRE

H.B.513, Chapter 227, Laws 1986 Limits the conditions under which liability insurance may be cancelled to nonpayment of premium; fraud or material representation affecting the policy; or a substantial increase in hazard. Prescribes notification periods for cancellation and nonrenewal of policies. Modifies the rule of joint and several liability so that defendants pay a portion of their liability that more closely approximates their percentage of fault. Permits the court to require a losing party to pay the costs and attorneys' fees of the prevailing party if it clearly appears that the action is frivolous or intended to harass the prevailing party. Prohibits punitive damages against a governmental unit for personal injury, bodily injury or property damage. Requires that actions be brought within three years of the act or omission, except when the injury and its causal relationship to the act were not discovered and could not have been reasonably discovered at the time of the act or omission. In these cases, actions must be begun within three years of the time the plaintiff discovers, or should have discovered the act or omission. Limits damages for noneconomic loss to $875,000. Requires the court to review attorneys' fees in all cases where the settlement is at least $200,000, including those that are settled prior to trial. Establishes a commission on tort law and insurance availability to study and make recommendations on these issues.

NEW JERSEY

A.R.57 Directs the Assembly Insurance Committee to conduct a thorough investigation of the insurance problems of state residents, including insurance coverage for professional liability.

NEW MEXICO

S.M.7 Requests the Health and Environment Department and the Department of Insurance to form a task force to study the problem of malpractice insurance for nurse-midwives and directs the task force to report its findings by November 1, 1986.

NEW YORK

A.B.11584 Grants the Insurance Superintendent greater authority to control malpractice insurance rates. Permits the superintendent to establish malpractice insurance rates for policy years 1985-86, for which no final rate had been established at that time, and for 1986-87 and 1987-88. Authorizes the superintendent to impose a surcharge beginning in 1989 to recoup any shortfall caused by the rates established for these years. Permits arbitration in cases where the defendant admits liability and authorizes HMOs to offer arbitration as an alternative method of resolving malpractice disputes. Establishes a monitoring program in the Health Department to review the performance of physicians who have been found lacking in skill. Imposes a requirement that certificates of merit be filed with malpractice suits. Authorizes a study of alternative approaches to medical liability. Declares intention to move toward claims-made malpractice insurance policies.

NORTH CAROLINA

S.B.1X, Chapter 6 Permits the Medical Malpractice and Medical Liability Study Commission to submit reports to the 1986 session of the legislature.

S.B.859, Chapter 1008 Establishes an exclusive procedure for compensating those injured by state mandated vaccinations. Authorizes the Industrial Commission to hear all claims for vaccine related injuries. Compensation may include actual expenses, loss of earnings, pain and suffering but not punitive damages. Limits awards for a single vaccination to $300,000. Claims must be filed within six years after the vaccine was administered or within the otherwise applicable statute of limitations, whichever is earlier. Grants the state a two year period in which to pursue a negligence action against the person who manufactured or administered the vaccine. Applies to claims for injuries received on or after October 1, 1986, and if the claimant requests, to viable claims pending at that time.

S.B.873, Chapter 1027 Permits the court to order payment of attorneys' fees and costs to the prevailing party in cases of a frivolous action or defense. Authorizes the Commissioner of Insurance to gather data from insurers and modify excessive rates.

OKLAHOMA

S.B.488 Limits punitive and exemplary damages to an amount not to exceed actual damages awarded, but exempts cases in which the court finds clear and convincing evidence that the defendant is guilty of wanton or reckless disregard for the rights of another, or oppression, fraud or malice. Allows the prevailing party to recover costs and attorneys' fees if the court finds that a claim or defense asserted by the nonprevailing party was asserted in bad faith or not grounded in fact or law. Limits the amount recoverable to $10,000. Requires the ten largest insurers in the state to file annual reports with the Commissioner of Insurance concerning a range of insurance products, including medical malpractice insurance. Creates the Select Committee on Insurance Rates and Tort Claims to study, prepare recommendations, and draft legislation concerning the problem of increasing liability insurance premiums and court awards.

RHODE ISLAND

S.B.2981, Chapter 350, Public Laws 1986 Grants insurers the authority to settle claims without the consent of the insured person. Freezes malpractice insurance rates from July 1, 1986 to June 30, 1987. Permits periodic payment of awards exceeding $100,000. Allows the court to award attorneys' fees to the winning party if it feels that a suit or defense was frivolous. Permits the introduction of evidence concerning payments from collateral sources. Requires the medical licensing board to maintain files for its own use and use by health care facilities and health maintenance organizations in connection with determinations about whether to grant staff privileges. The files are to contain information about malpractice suits brought against physicians, including dismissals and settlements, reports by hospitals and professional associations concerning disciplinary actions, reports of felony convictions and reports by PROs and insurers about sanctions imposed on physicians. Establishes a commission to study the rate structure, deficit and method of charging health care providers by the joint underwriting association, and its effects on health care costs.

SOUTH DAKOTA

S.B.281 Permits periodic payment of awards exceeding $100,000.

S.B.282 Limits malpractice awards to a total of $1,000,000.

UTAH

S.B.111 Limits awards for noneconomic losses to $250,000, but exempts punitive awards from this limit.

S.B.155 Permits the court to order periodic payments of awards over $100,000 in medical malpractice cases.

VIRGINIA

H.B.93, Chapter 389, Laws 1986 Modifies the two year statute of limitations for medical malpractice actions by extending it with regard to foreign objects left in a patient's body or fraud, concealment or intentional misrepresentation. In the case of a foreign object, the statute is extended one year from the time the object is discovered or should have been discovered. In cases where fraud prevented the discovery of the injury, the statute is extended one year form the time the injury is discovered or should reasonably have been discovered. These actions must be commenced within ten years of the time the cause of action accrues.

WASHINGTON.

H.B.1950, Chapter 300, Laws 1986 Requires hospitals to maintain coordinated programs for the identification and prevention of malpractice. The program must include the following: a quality assurance committee; a medical staff privileges sanction procedure through which credentials, physical and mental capacity, and competence in delivering health care services are periodically reviewed; a procedure for prompt resolution of grievances; the maintenance and collection of information concerning the hospital' experience with negative health care outcomes and injuries to patients; education programs dealing with patient safety and injury prevention; staff responsibility to report professional misconduct; and other programs. Requires licensed health care providers to report personal knowledge of unprofessional conduct on the part of a physician or the fact that a physician may be unable to practice medicine with reasonable skill and safety due to illness, alcohol or drug abuse, or the mental and physical conditions to the licensing board. Requires insurers to send reports to the medical disciplinary board of all malpractice settlements, awards, or payments in excess of $20,000. Also requires insurers to notify the board of the payment of three or more claims during a year resulting from a physician's alleged incompetence, regardless of the amount of the award or settlement. Directs hospital administrators to report termination or restriction of a physician's clinical privileges, or voluntary termination in order to foreclose or terminate action by the hospital. Requires hospital to keep written records of decisions to terminate or restrict physicians' clinical privileges. Requires hospitals to obtain information about physicians' background and professional experience prior to granting clinical privileges.

S.B.4630, Chapter 305, Laws 1986 Limits noneconomic damages to an amount determined by multiplying .43 by the average annual wage and by the life expectancy of the person incurring noneconomic damages. Eliminates joint and several liability except in the following cases: when a defendant acted in concert with another defendant or as the agent of another defendant; or when there is no contributory negligence on the part of the plaintiff. Modifies the statute of limitations by stipulating that the time for commencement of an action is tolled upon proof of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic diagnostic purpose or effect. Permits the court to order periodic payment of awards over $100,000 upon request. Requires the Commissioner of Insurance, as chairman of the tort reform study commission, to initiate a study of the effectiveness of joint underwriting associations. Directs the commissioner to submit a report to the legislature by January 1, 1991 on the effects of this law on insurance rates, the availability of insurance and the impact on the court.

S.B.4749, Chapter 148, Laws 1986 Requires insurers to submit information regarding medical malpractice insurance to the Insurance Commissioner. The information must include data about premiums, investment income, claims, reserves, expenses, underwriting and operating gains and losses.

WEST VIRGINIA

S.B.714 Requires the Board of Medicine to initiate an investigation upon receipt of notice that five or more judgments or settlements arising from medical professional liability have been made against a practitioner. Requires professional associations which take formal disciplinary action against a member relating to professional ethics, incompetence, malpractice, moral turpitude or drug or alcohol abuse to report this action to the board within 60 days. Requires the Insurance Commissioner to hold rate hearings when insurers file rate increases above 10%. Prohibits insurers from canceling or failing to renew policies, except for one or more of the following reasons: failure to pay premiums; material misrepresentation; violation by the insured of the terms and conditions of the policy; evidence, such as suspension or revocation of license, that indicates that the insured is an increased risk; or the unavailability of reinsurance. Requires insurers to inform insured policyholders of the reasons for cancelling or failing to renew a policies, and prescribes notification periods. Limits awards for noneconomic losses to $1 million. Allows payment of costs and reasonable attorneys' fees to the prevailing party if the court determines that the claim or defense was frivolous or dilatory. Requires that testimony of expert witnesses meet the following conditions: the opinion being given is that of the expert witness; the opinion can be testified to with reasonable medical probability; the expert possesses professional knowledge of the applicable standard of care to which his or her testimony is addressed; the expert maintains a current license to practice in the U.S.; the expert is engaged or qualified in the same or similar field as the defendant. Modifies the statute of limitations to require that actions be commenced within two years of the date of injury, or within two years of the time the person discovers or should have discovered the injury. Stipulates that no actions may be commenced more than ten years after the date of the injury. Directs the Insurance Commissioner to study the feasibility of creating joint underwriting associations or alternative pooling arrangements to facilitate the issuance and underwriting of malpractice insurance in the state.

H.B.149X Note: Governor Moore called a special legislative session to revise some of the provisions of S.B.714. In response to the passage of that bill, some insurers withdrew from the state, complaining of excessive regulation of the insurance industry. They found some of the bill's provisions regarding reporting of insurance claims and activities and restrictions on cancelling or not renewing insurance policies onerous. Rescinds the requirement, imposed by S.B.714, that insurers file information about claims on an individual basis and requires them to report on an aggregate basis instead. Removes the restrictions under which policies can be subject to nonrenewal and makes these restrictions applicable only to cancellations. requires the Commissioner to hold a hearing within 60 days of the time a rate increase is requested.

WISCONSIN

A.B.4-XX, Act 340, Laws 1986 Limits payment of noneconomic damages in either judgments or settlements to $1 million, adjusted annually for inflation. Requires itemization of malpractice awards. Requires insurers to provide information to the Insurance Commissioner concerning medical malpractice insurance. The information must include data about premiums, number of people insured, reserves, claims, investment and income gains and losses, number of legal actions filed, and number of verdicts or judgments. Directs insurers to notify the commissioner upon cancellation or nonrenewal of insurance. Requires hospitals, the Department of Health and Social Services, insurers, HMOs, limited health service organizations and PPOs to notify the medical examining board of any disciplinary action taken against a licensed provider. Limits attorneys' contingency fees to 25% of the first $1 million, if liability is stipulated within a certain time period, and 20% of any amount in excess of $1 million. Permits the court to approve attorneys' fees in excess of these limits upon a showing of exceptional circumstances. Requires that all awards be made in present dollars unless a structured settlement is adopted. Creates an informal, nonbinding but mandatory pretrial mediation system to replace the state's formal panel hearing system. Makes a number of changes in the patient compensation fund and in the health care liability insurance plan.

WYOMING

H.B.5 States that the signature of an attorney or party filing a suit constitutes a certificate that, to the best of his knowledge, information and belief, the action is well grounded in fact, is warranted by existing law or a good faith argument and is not intended to for any improper purpose, such as to harass or cause unnecessary delay or increase in the cost of legislation. Permits the court to order the payment of attorneys' fees if this certificate is signed in violation of the law.

H.B.28 Specifies that the burden of proof in civil actions involving health care providers rest with plaintiffs.

S.B.17 Eliminates the doctrine of joint and several liability. Provides that defendants are only liable for their percentage of fault. Stipulates that contributory negligence does not prohibit plaintiffs from recovering damages as long as their negligence does not exceed 50% of the total fault.

H.B.40, Chapter 92, Laws 1986 Establishes a medical review panel to review all malpractice claims except those subject to a valid arbitration agreement or upon which suit has been filed prior to July, 1, 1986. Prescribes the membership, duties and powers of the panel. Stipulates that the panel's decisions are not binding and are not admissable into evidence.

The **Chairman**. Our next witness today is the Honorable Robert J Mrazek, a Member of Congress from New York State. We look forward to taking your testimony at this time, Congressman Mrazek. So welcome to the committee. We are glad to have you here.

We hope you will be able to summarize, and we will just move ahead.

STATEMENT OF HON. ROBERT J. MRAZEK, A MEMBER OF CONGRESS, FROM THE STATE OF NEW YORK

Mr. **Mrazek**. Mr. Chairman, I thank you for the opportunity to testify before your subcommittee today, and I formally request that my rather lengthy, detailed statement simply be submitted for the record.

The **Chairman**. Without objection, we will put it in the record.

Mr. **Mrazek**. Mr. Chairman, it is fair to say that malpractice negligence does occur, in fact, in every sector of our society. I would submit to you that when former Vice President Walter Mondale stood up at the Democratic National Convention in 1984 and said to the American people, "I am going to raise your taxes," it was, in fact, political malpractice.

By the same token, when former President Nixon decided in his internal wisdom, "I am going to tape all of my conversations in the White House," I would consider that to be a form of malpractice.

There is a difference between malpractice and bad results. And if one wants to take the case of Ralph Branca serving up a certain pitch to Bobby Thompson, I think you could call that "bad result," rather than necessarily "negligence" on his part as a pitcher.

There are a lot of other examples that I am sure we could find of malpractice or bad results in many different sectors of our society. But we do have, in fact, a national crisis on our hands when it comes to the issue of medical malpractice and malpractice reform.

I have the dubious distinction of representing an area of the country where doctors pay the highest malpractice insurance premiums in the United States; where, in some cases, doctors in certain specialties are paying more than $100,000 a year simply to continue practicing, and there has been a direct result from those dramatic increases in malpractice insurance premiums in New York. The result has been that our best young residents, who are studying at some of the finest hospitals in our country, have decided that they are not going to stay in New York; they are, in fact, going to move to other parts of the country where the crisis has not quite hit with the same negative connotations. Now, that is good—perhaps temporarily—for a lot of other States, when we lose 40 percent of our best young doctors in New York, but the problem is not going to be limited to New York.

In the Midwest, for example, we saw a 216 percent increase in the incidence of malpractice suits in just 1 year. I know of physicians in New York who are deciding not to handle certain cases. I know of an orthopedic surgeon who refused to handle a traumatic injury case at an emergency room at a hospital in Suffolk County.

We have a crisis of course, that, has a tremendous financial pricetag attached to it. I know of many senior citizens in particular who question why doctors in hospitals seem to perform so many unnecessary tests. Well, we know that is called "defensive medicine." And it is fair to say that hospitals and doctors, deeply concerned about the potential for being sued, have utilized a lot of tests simply to avoid someone saying that by not giving this test, they failed to take proper precautions and were negligent.

The estimated cost alone for defensive medicine is $15 billion a year in this country, and, of course, we find that the Federal Government pays a substantial portion of that commitment.

Right now in New York, the average length of a court case when someone brings a malpractice claim is 8 years for final adjudication. Eight years in which doctors who might be negligent are, in fact, able to continue practicing. Eight years in which many doctors who are not guilty of negligence have hanging over their heads one or more suits over a period of time that would cause a tremendous amount of internal pain to any of us. Eight years in which victims of negligence have to wait before receiving some compensation. And when you get to the end of that 8-year-period, Mr. Chairman, we find that the victims on average receive 28 cents out of each dollar that is ultimately spent.

I would like to join with Secretary Bowen in applauding your leadership on the issue of medical malpractice reform. As far as I am concerned, your legislation does take some very important steps forward in trying to address this challenge.

But with all due respect, I do not think that a cap on pain and suffering, or collateral source rules, or structured payments rather than lump sum payments, or limits on contingency fees, will, in fact, solve the problem that we are trying to address when it comes to malpractice reform.

In my view, there is an alternative, and it is the heart of legislation that I have introduced in the House, H.R. 2659, the Medical Malpractice Reform Act. The fundamental difference between that legislation and what you have introduced is the introduction of adjudication panels to resolve cases of malpractice on a strict standard of negligence.

Now, these adjudication panels would be different than any other adjudication or arbitration panels that have been tried in any State of this country. We would not through this legislation force adjudication panels on a State, but we would, as in your bill, provide incentives to those States that would like to participate in setting up adjudication panels. And each State through its attorney general's office would apply to the Federal Government to be reimbursed for the establishment of these panels.

Now, what are they? What would they be? These panels would have the opportunity to fairly and expeditiously—under the rules of law in that given State—adjudicate claims against doctors who have allegedly committed malpractice or negligent service. The panels would be made up of three components: a member of the State bar association of that State a member of the State medical society—hopefully, a health care practitioner with the same specialty that is being considered in that particular lawsuit and a layperson—a neutral party, an arbitrator in a sense, someone with that kind of experience, a reputation for objectivity and common sense. And they would hear the cases. They would be able to subpoena witnesses, independent witnesses, independent medical testimony. They would be encouraged within 1 year to resolve these cases. They would have the power, in fact, to determine not only liability, but also the amount of the award. Other arbitration panels in other States have had the power to determine liability, but they have not been able to determine damages. In those situations, panels had simply become one more step in the long process by which one party or the other took the case to court.

The panels that I am talking about would have the authority to dismiss frivolous claims, unmeritorious claims, and I think that is very important. Ultimately, the decision they would reach would determine if, in fact, negligence has been committed; if it has, what damages should be provided to the victims of negligence.

At that point, the case would be resolved. If, in fact, either the plaintiff or defendant was unhappy with the verdict by the panel, they could go to the appellate division of that State's Supreme Court and make a case why the decision was erroneous. If the high court was found that the case was determined on an erroneous basis, they could order a trial de novo; otherwise, a trial would not take place.

Basically, in other words, I came to the conclusion after a lot of independent research—the kind of research that the task force of Secretary Bowen is going to be undertaking, that we have to take the question of liability reform in this area out of the adversarial court process, in the interests of both the victims of negligence and the doctors who have not committed negligence.

I thank you very much for listening to my testimony, and I hope you will, at least, consider taking a good look at that component of my bill which differs from yours.

[The prepared statement of Mr. Mrazek (with an attachment) and response to questions submitted by Senator Hatch follow:]

TESTIMONY OF CONGRESSMAN ROBERT J. MRAZEK BEFORE THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

Mr. Chairman and members of the Committee, I am pleased to have the opportunity to testify here today regarding the single most important issue confronting our nation's health care delivery system: the crisis in medical professional liability.

I am not going to even attempt to assess blame. I'll leave that up to the physicians, lawyers, and insurance people to continue to fight it out amongst themselves. Suffice it to say, there is plenty of blame to go around. Yes, there is malpractice and, unfortunately, there are incompetent doctors out there. Questionable investments on the part of the insurance industry and the state of our current judicial system have equally contributed to the present situation. My primary concern in this area is to find a solution -- to find a way to ensure that all Americans will continue to have access to affordable and quality health care.

In my estimation, today's medical liability situation has reached a critical stage. Malpractice premiums for physicians continue to skyrocket. In my home district on Long Island, doctors have the distinction of paying the highest premiums in the nation and will soon be facing yet another series of premium hikes.

Dramatic increases in the number of claims and high jury awards have created a situation where doctors are forced to practice defensive medicine, adding billions to the overall cost of health care. Insurance loss growth continues to outpace premium growth despite the increase in premiums. Reserves held by liability insurance companies are estimated to be hundreds of millions of dollars short of what will be needed to pay future liabilities.

More compelling than the economic costs are the human dimensions of the crisis, and its effect on the quality of health care in this country. The fear of litigation is so great that we are witnessing a variety of unsettling developments: neurosurgeons refusing to perform high risk surgery; obstetricians turning away expectant mothers; trauma patients being denied treatment; family practitioners retiring early or curtailing their practices.

Perhaps the greatest rift that is being created by the crisis is the increasing erosion of trust between doctors and their patients. Unfortunately, many competent and understanding doctors must now look upon patients as potential litigants in future lawsuits. Paradoxically, it is often our most gifted and talented physicians, those willing to tackle the complex and high risk cases, who are sued for malpractice.

This highlights yet another issue. With the truly incredible advancements made in medical technology and procedure over the past decade has come perhaps unreasonable or at least overestimated expectations on the part of patients. Medicine is not yet an exact science. The most brilliant physician using the most sophisticated equipment still cannot guarantee a perfect baby or a perfect recovery from complex surgery. In medical liability, a clear distinction must be made between true negligence and simply "bad results."

Turning to our legal system, I have become convinced that the fundamentally adversarial nature of our tort system is simply not the best way to resolve the many complex aspects of professional liability. Today, the average claim filed in our court may take up to eight years to be decided. A patient with a dramatic or a sympathetic injury can end up with millions, while others with more legitimate claims might leave court with nothing.

In hundreds of cases throughout the country, awards routinely exceed $1 million. Yet approximately three-fourths of the cost of the present system goes not for compensation of victims of medical negligence, but for the costs of long trial delays, high administrative costs, and attorneys' fees. Ultimately, only 28 cents of every dollar paid for malpractice insurance reaches the injured party.

Mr. Chairman, the patterns that I have just outlined are nationwide. I applaud the efforts of this Committee to call attention to this most urgent health care problem. While state governments have historically had legislative control over the malpractice issue, it is clearly time for the federal government, which today pays for over one-third of the nation's total health care costs, to play a major role in malpractice reform.

In an effort to alleviate this health care crisis, I have introduced comprehensive reform legislation in the House of Representatives, HR 2659— The Medical Malpractice Reform Act. I would like to take a moment to review several of the major components of the proposal. It will be clear that Senator Hatch and I share many of the same thoughts on what may very well be effective and long-term tort reform. I am pleased that we agree on most of these important principles.

The legislation that I have introduced attempts to ease the current malpractice crisis by assuring the equitable financial reparation of victims of medical negligence, providing for the prompt resolution of claims, and reducing the burden on our court system. It creates federal financial incentives to encourage reform on the state level. Its major provisions would:

- encourage states to establish medical malpractice arbitration panels to hear and resolve malpractice claims,
- give panels the authority to dismiss frivolous claims,
- allow information on collateral sources of payment in evidence for the sole purpose of determining the amount of the award,
- allow for structured settlements rather than lump-sum payments of awards,
- cap recoveries for non-economic losses to compensate for pain and suffering at $250,000,
- allow for judicial review of a panel's decision,
- limit attorneys' contingency fees,
- enable states to authorize insurance companies offering malpractice coverage to charge higher premiums to health care providers who have been found guilty of malpractice or who have entered into three or more settlement agreements, and
- encourage states to establish risk management programs.

Many of the same reforms incorporated in my legislative proposal are included in the Hatch bill and were recommended by the American Medical Association's Special Task Force on

Professional Liability. I am convinced that these reforms are essential to stabilizing the current situation.

The major difference in my approach is the creation of arbitration panels to hear and decide all claims resulting from medical malpractice. The panels will be composed of at least three members, with at least one health care professional, one member of the state bar and one layperson. Individual states may establish as many panels as necessary to expedite claims.

Hopefully, these panels will not only aid in reaching just and timely solutions of claims, but will significantly lower administrative and litigation costs.

Continued court delays and inconsistency on the part of juries will only serve to further exacerbate the problem. Allowing panels to assess liability and to decide on the amount of the award will not only expedite the process, but will enable experienced and knowledgeable decision-makers to produce fairer and more reasonable settlements.

While I am aware of potential legal issues that may be raised by this arbitration approach, truly effective reform will require, in my view, an alternative mechanism to the judicial system. I firmly believe that if properly designed, state statutes providing for the creation of malpractice panels will pass constitutional muster.

In the past, several states have experimented with non-judicial malpractice claims systems, using screening panels without a great deal of success. These panel systems were generally established on a voluntary basis or had limited authority to arbitrate claims. Most panels of this nature could only assess liability, thus assuring that a case would eventually have to go to trial. Ultimately, this leads to a needless and expensive duplication of efforts that slowed down the process even more.

The kind of arbitration panel I have in mind differs greatly from the screening panel approach. If an arbitration system is to be truly successful, panels must be able to dispose of cases permanently. The panel system set forth in my legislation gives panels this needed authority. Under my proposal, arbitration panels will assess liability, determine awards, and have the authority to dismiss frivolous claims. Of course, my legislation also includes provisions that would allow for judicial review of a panel's decision. Nonetheless, a high standard of review would apply.

I would also like to briefly comment on two other aspects of my legislation. Although no price can truly recompense some injuries, I believe that I have proposed a very reasonable cap of $250,000 on recoveries for non-economic losses to compensate for "pain and suffering." It is important to note that recoveries for economic losses would not be limited in any way. Injured persons would still be able to receive full compensation for injuries that inhibit their ability to earn an income.

It is the very difficulty in attaching monetary values to "pain and suffering" that perpetuates one of the major issues associated with the malpractice crisis -- the unpredictability of the size of non-economic damages awards. The $250,000 limit would serve to reduce the large disparities among award sizes and help reduce overall malpractice costs.

Incidentally, a similar California statute has been upheld by the U.S. Supreme Court.

In assessing the current situation, there are two immediate concerns. First, how can we quickly and fairly compensate malpractice victims? I believe the arbitration approach, along with other reforms, will go a long way in achieving this goal. Second, how can we reduce the incidence of medical malpractice?

As my research on the malpractice issue has progressed, I have had the opportunity to speak with hundreds of physicians from throughout the country. The great majority are highly skilled and competent professionals. Nevertheless, as we all know, bad doctors do exist. Most doctors would be the first to say that it is absolutely essential to weed out the "bad apples" of their profession.

In an effort to ensure physician accountability, my legislation directs states to authorize insurance companies offering malpractice coverage to charge higher premiums to providers with a history of malpractice. States would also be encouraged to establish risk-management programs to develop measures that will reduce the frequency of avoidable injuries to patients.

Mr. Chairman and members of the Committee, I would like to again thank you for this opportunity to address a most urgent issue. Debate will no doubt continue on the origins of the crisis or for that matter, whether a crisis even exists. When doctors are forever changing the way they practice, when the nature of the doctor-patient relationship is changing, when the very availability of health care is being questioned, I would contend quite strongly that a crisis situation does exist.

Unless positive action is taken, the situation will only worsen. I believe there is a federal role to play, and hope that some of my proposals will be considered favorably. In any event, I look forward to working together with members of this Committee and my colleagues in the House in an effort to bring about effective and constructive reform in the months ahead.

THE MEDICAL MALPRACTICE REFORM ACT (HR 2659)

Introduced by Congressman Robert J. Mrazek

The legislation will establish a program in the Department of Justice to fund state medical malpractice programs which comply with minimum federal standards. It creates financial incentives for states to take certain reform measures in order to ease the malpractice crisis.

Medical Malpractice Arbitration Panels: To receive payments, a state must establish one or more medical malpractice arbitration panels which will have at least three members, with at least one health care professional, one member of the state bar, and one layperson. All claims for damages resulting from malpractice will be heard and decided by the panels using expedited procedures.

A health care professional serving on a panel, wherever practicable, will represent the same medical specialty as the defendant. In cases involving multiple defendants, a representative from each defendant's specialty will be appointed to the panel. In such cases, no more than three health professionals will be appointed. These professionals will cumulatively have one vote on the panel.

-- The use of arbitration panels on a nationwide basis will provide a means of encouraging prompt and fair settlements of malpractice claims and reduce the burden on the court system. Today, the average claim filed in court may take up to eight years to be decided. Establishing these panels will not only aid in reaching just and timely resolutions of claims, but will lower administrative and litigation costs.

Many states have experimented successfully with nonjudicial malpractice claim systems using panels. Other states have had less success primarily because the panels had been established on a voluntary basis or had only limited authority to arbitrate claims. The legislation sets forth minimum standards designed to give these panels the necessary power to expedite cases, while at the same time, give the states the flexibility to shape individual systems to fit local needs and conditions.

Panel decisions: Malpractice claims will be adjudicated according to the state law in which a panel sits, subject to any special rules that the State Attorney General may promulgate. A panel is encouraged to decide a claim within one year after the date on which the claim is filed.

Information on collateral sources of payment: Such evidence will be permissible for the sole purpose of determining the amount of an award. The amount of any collateral source payments received will be deducted from the panel award.

-- Studies have indicated that modifying the "collateral source rule" will bring about cost savings by preventing plaintiffs from receiving a double recovery for their injury.

Frivolous claims: Panels will have the authority to dismiss claims that it determines to be frivolous and to impose administrative costs upon claimants who pursue cases which are determined to be frivolous.

-- If a panel system is to be effective, it must have the authority to weed out unmeritorious claims. This provision would apply to a party which has commenced a frivolous claim or against a defendant who has interposed a frivolous defense.

Award of damages: If a panel finds a compensable injury resulting from medical malpractice, the panel will determine the amount of damages owed. The panel will provide for structured settlements in annual or other periodic payments, rather than lump sum payments to reduce the impact of awards on medical insurers.

-- Increasing jury awards have clearly had a significant impact on the severity of the current malpractice crisis. Allowing panels to decide on the amount of the award will permit the use of experienced and knowledgeable decision-makers who will be able to produce fairer, more reasonable settlements of malpractice claims.

Limit on amount recoverable for noneconomic losses: A claimant will be entitled to recover noneconomic losses to compensate for pain and suffering and other non-pecuniary damages. However, recoveries for pain and suffering may not exceed $250,000.

-- The U.S. Supreme Court has upheld the constitutionality of a California law which caps pain and suffering payments at $250,000. Limiting noneconomic damages will reduce distorted awards in liability cases and help stabilize overall malpractice costs.

Judicial review: Any party to a claim decided by a panel will be allowed to appeal the panel's decision to the state court of appropriate jurisdiction, as determined under state law. A high standard of review will apply: the court reviewing the case will uphold the panel's decision unless it finds it to be clearly erroneous or in violation of the rules and procedures set forth in the bill. If the court finds a panel's decision to be clearly erroneous, the appellant will be entitled to a trial de novo and the right to a trial by jury.

-- The key to a successful arbitration system is that the panels must be able to permanently dispose of cases. This approach makes the panel system more effective and appeals less likely. At the same time, it maintains the right to due process by allowing a plaintiff or defendant to appeal in court and to receive a new trial under certain circumstances.

Report of panel's findings: The panel, after rendering its decision, must transmit a report of its findings to the state insurance commissioner. The state will provide that insurance companies offering malpractice coverage are authorized to charge higher premiums to health care providers with a history of malpractice liability. This is designed to ensure accountability on the part of the health provider.

Award of attorney's fees: Each state will provide that the amount of payments to a claimant's attorney will be limited to a standard contingency fee formula. A lawyer could collect no more than one-third of the first $100,000 of any judgment and is limited to a progressively declining share of each additional $100,000 increment.

-- All too often in malpractice cases today, attorneys receive anywhere from 25% to 50% of the eventual malpractice award. Establishing a sliding scale for contingency fees will help ensure that the bulk of the award goes as compensation to the injured party, not the attorneys. The U.S. Supreme Court has rejected a challenge to a California law which limits contingency fees.

Payments to states: The U.S. Attorney General will make payments to states in two installments. The Attorney General will allocate funds based on the needs of individual states. In making this determination, the Attorney General will consider the need for states with a high incidence of malpractice claims to have a sufficient number of panels to expeditiously process these claims. If thirty months after enactment, a state has not complied with federal standards, the Attorney General will reallocate funds to states most in need of additional funding. A total of $500 million is authorized annually under the bill.

Recommended actions: States are encouraged to establish risk management programs to develop measures which will reduce the frequency of avoidable injuries to patients. States are also encouraged to establish public awareness programs to educate the public about the severity of the malpractice crisis and its negative impact on consumers.

Answers of Congressman Robert J. Mrazek to Questions
Submitted by the Senate Committee on Labor and Human Resources
on Medical Malpractice Hearing Testimony

Arbitration Panels

1. I believe there is limited experience with arbitration panels. Do you have any data which suggests that arbitration panels would help?

ANSWER : Many states have experimented successfully with nonjudicial malpractice claims systems using panels. Other states have had less success primarily because the panels had been established on a voluntary basis or had only limited authority to arbitrate claims. But you are correct that at present we do not have a lot of hard data on which to pronounce final judgement, primarily because no one, to my knowledge, has undertaken such an effort, given the relatively short time some of the panels have been in existence and the extent to which the panels vary from state to state.

I want to re-emphasize here the important distinction between how many arbitration panels have been set up in the past and what my legislation proposes. To receive payments, the states would have to establish what are actually adjudication panels, empowered to hear, decide, and dispose of cases. This authority will allow the panels to reach just and timely resolutions of claims as well as lower administrative and litigation costs.

2. Would you propose that the arbitration panel be voluntary? If so, would entry into arbitration prevent future access to litigation? I understand panels prevent access to litigation, few plaintiffs choose arbitration. How would you respond to this?

ANSWER: The key to a sucessful arbitration, or adjudication, system is that the panels must be able to permanently dispose of most cases in a fair, expeditious process. At the same time, this system maintains the right to due process by allowing a plaintiff or defendant to appeal the panel's decision to the state court of appropriate jurisdiction, as determined by state law. But this legislation does not make panels just one more layer in an already protracted judicial process. A high standard of review will apply to all appeals; the court reviewing the case will uphold the panel's decision unless it finds it to be clearly erroneous or in violation of the rules and procedures set forth in the bill. If the court finds a panel's decision to be clearly erroneous, the appellant will be entitled to a trial de novo and the right to a trial by jury.

It is also worthwhile to note that despite the high settlements awarded some plaintiffs, much of the money awarded never gets to the injured party. About three-fourths of the legal costs in malpractice cases go not for the legitimate compensation of victims of malpractice but instead to the costs of long trial delays, high overhead, and attorneys' fees.

Periodic Payments:

1. During the second of our hearings on Malpractice, a representative of a malpractice victims organization stated that structured settlements rather

than lump sum payment of awards has adverse impact on victims and may lead to victims being awarded inadequate funds for necessary medical expenses. When this occurs, there may be no money available from past reserves, no loans available to be secured against next year's share, and no medical assistance program to fall back on. How would you respond?

ANSWER: My legislation would provide for the timing and amounts of periodic payments in a manner that would avoid hardship to, and assure full compensation of, each person to whom the award is made, as determined by the panel or a State court reviewing the claim. This provision ensures that the types of concerns you raised do not, in fact, occur. Additionally, because of reduced litigation costs and limits on lawyer contingency fees, the victim of malpractice is likely to end up with more money in his or her pocket.

Closed Claims Data

1. While insurance claim files remain closed and while we have little data available from insurance companies about their files, don't you agree that estimating the impact of the specific tort reforms is difficult, if not impossible?

ANSWER : It has been estimated that the Chairman's bill would save $500 million a year. Since my bill contains many of the same provisions as well as additional cost-saving measures, I think it would be safe to expect that my approach will save at least as much -- if not more.

Doctor Discipline

Aside from the high risk specialties such as Neurosurgery and Obstetrics, it has been shown that in at least one state (Florida) where the data is available a small percentage of the Doctors are responsible for a large percentage of the malpractice cases. How do you propose to deal with the problem of Doctor discipline?

ANSWER : My bill requires that the state insurance commissioner and the appropriate licensing or certification body be notified within 30 days of any finding of medical malpractice by a panel or appeals court or settlement agreement and that the report be available for public inspection. State insurance commissioners shall promptly notify each state malpractice insurance provider who will be authorized to adjust its rates for persons found liable by a panel or court, or who have entered into three or more settlement agreements requiring payments within the three years prior to application for malpractice insurance.

States are also encouraged to establish programs designed to prevent or reduce malpractice; to develop or improve oversight mechanisms, including risk management and licensing and certification programs; and to develop educational materials for both the doctor and the consumer about standards of care and medical malpractice.

Additionally, the State Attorney General is also encouraged to develop a program to identify, investigate, and report on all incidents of malpractice in health care facilities and to encourage the facilities to take steps to reduce malpractice.

The **Chairman**. Thank you so much. I will take a good look at it, and we appreciate you taking the time from your busy schedule to come over and inform our committee about your bill. We appreciate it very much.

Mr. **Mrazek**. Thank you very much, Mr. Chairman.

The **Chairman**. Thank you. We appreciate having you here.

We are now going to turn to Miss Mary Sacco, who is accompanied by her mother, Mrs. Anne Sacco, from Massachusetts, and Dr. Francis S. Rockett, from Newton, MA. We would like you to take your place at this time.

We are really happy to welcome you folks here today, and Dr. Rockett—I hope I am pronouncing your name right.

Dr. **Rockett**. Yes, Senator.

The **Chairman**. We are happy to have you here. We think your testimony is particularly important.

I have to apologize to you, because I am the floor manager on the Rehnquist nomination, and I have to be there in 6 minutes. So what I am going to do is, I have Mr. Ryan our counsel for the Labor Committee, I am going to ask him to take the remaining testimony today—unfortunately sometimes, we just get caught on these things—and make this very, very important record.

Mary, we are so happy to have you here.

Miss **Sacco**. Thank you very much. I am glad to be here.

The **Chairman**. OK. Thank you.

I am going to ask Mr. Ryan to take the rest of the testimony. We think this testimony is particularly important, along with the other testimony that we have had in the prior two hearings because Dr. Rockett, we understand some of the difficulties you are going through and that therefore, by necessity, Mary will have to go through if we cannot resolve these problems.

I am very concerned about it, and I hope you will forgive me for having to leave for the floor, but I just do not have any alternative. And all of our other Senators, believe it or not, are all similarly busy, so we will do it that way. It is a rare ocasion when we do it that way, but I do not have any other alternative today.

So with that, let us turn and begin with the testimony.

Mr. **Ryan** [presiding]. Mrs. Sacco, I wonder if you would kindly summarize the medical condition of Mary and how it relates to the malpractice insurance crisis?

STATEMENT OF MARY SACCO, ACCOMPANIED BY ANNE SACCO, MILTON, MA; AND DR. FRANCIS X. ROCKETT, NEUROSURGEON, NEWTON, MA

Mrs. **Sacco**. I delivered Mary; prior to her delivery, I had toxemia and nephritis. Mary was born premature. She had Highland membrane at birth. She developed a hemorrhage in the brain, which led to fluid over the brain. And we were very fortunate to have a good pediatrician to call on, Dr. Rockett, to help us with Mary.

Dr. Rockett has performed several operations, the first by implanting a shunt to drain the fluid from her head. Her head grew quite rapidly in the first year; it grew in the high percentile, with hydrocephalus, which is fluid compressing her brain. So Mary did very little of anything in the first 2 years of her life. She was pretty much a vegetable. If it was not for Dr. Rockett and his dedication and the series of operations he performed on Mary to help her function and live like a normal person. She has made really great progress.

She has been mainstreamed into the Milton public schools and has made great, great gains there. She was the national poster child during the year 1982, the first child ever from Massachusetts. And a lot of people, looking back, never expected Mary or even myself to do that. She traveled all over the country, fundraising for Easter Seals, and did an incredible job.

She is still making great gains. And we did develop a more serious crisis at the end of her tour when she was the national child. She developed a clot over the left side of the brain. Dr. Rockett was there again to help us, to perform very, very serious operations to get the blood clot under control. It took four brain operations to get Mary back to where she is today.

We thank God that we have Dr. Rockett as our neurosurgeon. I do not know what we would do without him.

Mr. RYAN. Thank you.

How would it affect Mary's progress if Dr. Rockett had to move his practice to another jurisdiction?

Mrs. SACCO. Well, we would have no other choice but if Mary would be able to fly to wherever he would be. I hope we never see that day happen, because it will be devastating to Mary and to many other patients that are depending on Dr. Rockett. So I really would not have the same security going to another neurosurgeon. It is not like changing pediatricians. It is very serious when you change to another brain surgeon.

So I hope Dr. Rockett will always be with us.

Mr. RYAN. Well, we hope so, too.

At this time, on behalf of Senator Hatch and Senator Kennedy, who unfortunately could not be here this morning, we would like to give a special welcome to you, Mary. We know all you have been through and the help that you have had from Dr. Rockett.

Mary, would you give us some of your feelings, please, if Dr. Rockett had to move to another State?

Miss SACCO. Yes, I will. I feel——

[Pause.]

Mr. RYAN. It is all right. It is all right. Take your time.

Mrs. SACCO. He is not going to leave, Mary. He is going to stay with you.

Mr. RYAN. It is all right. Thank you, Mary. Do not worry about it. It has been quite a strain for you through all of this problem.

Mrs. Sacco, have you considered what you would do if Dr. Rockett had to relocate?

Mrs. SACCO. Well, as I said before, it makes it very difficult to go wherever if he did relocate. Mary is going to, I am sure, have more operations as time goes on, because she depends on a shunt to drain the fluid from her brain, and the shunt does obstruct or build up fluid over the brain. So we may not be able to fly her. It depends on her condition at the time.

So really, I hope he never leaves Massachusetts for that simple reason. I hope we will always have him when we need him.

Mr. RYAN. Thank you, Mrs. Sacco.

What I would like to point out is that Mary attends school in the Milton school system in Milton, MA. Tomorrow, the Tucker Elementary School of Milton will receive a flag of excellence from President Reagan and Secretary of Education Bennett in the National Elementary School Recognition Program.

With us today in the hearing room are those who are present to receive that award, and I would like to give recognition to them: Dr. Frank Juliano, superintendent of schools; Ms. Mary Schofield, assistant superintendent for academic affairs; Mr. Frank Guarino, principal at Tucker Elementary School, and Mrs. Patricia McNaught, chairperson of the Milton Public Schools.

We are glad to have you here.

Dr. Rockett, would you please give us your testimony? You have been quite helpful in taking care of Mary, and we all recognize the benefit of your fine care and treatment, and we hope that we are going to be able to help solve this problem so that we do not have to experience the kinds of crises that we are looking at now.

Would you please proceed, Doctor?

Dr. ROCKETT. Thank you, sir, thank you, Mr. Chairman and members of the committee, for the opportunity to appear before you and discuss some of the problems associated with the medical liability crisis.

I am Francis X. Rockett, a neurosurgeon from Greater Boston. With me today is Mary Sacco, who has been my patient for 13 years, and her mother, Mrs. Anne Sacco.

Mary has accompanied me today because we are physician and patient in a mutually rewarding relationship. We represent the everyday reality of medical care in this country.

Mary faced very serious difficulties at birth. As an infant, she required a great deal of specialized care. She received that care, then and over the years, not only from me, but also from many others.

I cannot express the satisfaction that I have derived from watching Mary Sacco grow and develop into a truly delightful person.

As Mary's neurosurgeon, I first saw her when she was only a few weeks old. At that time, she needed to have a shunt implanted to transfer excessive fluid from her brain, fluid that otherwise would have been retained with devastating consequences.

Over the last 13 years, it has been necessary for me to repair and replace her shunt on several occasions.

Mary started with more strikes against her than most could survive. Yet she has been an incredible fighter and, as I said, is a delightful person. It would be a great loss to me if I were forced to leave Mary in Massachusetts in order to continue to practice neurosurgery, which was very nearly the case this year.

I have practiced neurosurgery in Massachusetts for 22 years. In order to prepare for my specialty, I attended Harvard Medical School for 4 years after graduating from Tufts College. I did 1 year of internship at Boston City Hospital, and then underwent 4 years of residency training at Boston Children's Hospital and Peter Bent Brigham Hospital.

While my wife and five children love Massachusetts, we were ready to make the necessary sacrifices when it appeared that I would have to leave the State in order to continue practicing neurosurgery.

Earlier this year, I began the process of relocating to another State. The decision to leave Massachusetts was forced upon me by the medical malpractice crisis. The very skills that allow me to save lives and alleviate suffering place me in the highest-risk category for malpractice claims.

At the beginning of this year, I faced the very real prospect of having no net practice income after payment of my malpractice insurance bill.

Under Massachusetts law, physicians must accept fees established by Medicare, Medicaid, workers compensation and Blue Shield as payment in full, but none of those programs were adjusting their fees to cover the sharp increases in the cost of malpractice insurance that we were experiencing.

I therefore could not recapture the increased cost of insurance by increasing my fees, nor could I absorb the increases, nor could I increase my workload without compromising the quality of care received by my patients.

I am too young to retire, and I am not willing to give up surgery so long as I can help my patients. I had but one option, and that was to practice somewhere other than in Massachusetts.

As I made my plans, I began to seek another neurosurgeon to take care of Mary. I found that well over 50 percent of my colleagues were also considering such drastic changes in their practices. I also discovered that in other States, these rapidly escalating costs are being passed on—thereby directly increasing medical costs more than any other inflationary factor.

Fortunately for me and many others, our State passed legislation in July which relieves the most immediate pressures we had been experiencing. That legislation recognizes the need for tort reform by placing a $500,000 cap on awards for pain and suffering, by limiting attorneys' contingent fees, and by limiting the collateral source rule in medical liability cases.

While we believe that the new limits are not sufficient, they do mark an important first step in resolving the problem. However, if more is not done in Massachusetts, if more is not done nationally, then many of us will have to leave medicine and surgery.

The public debate over medical malpractice has obscured the real issue, which is the future of medicine in this country. The current system is destroying medicine.

You should not lose sight of the fact that there are millions of encounters between physicians and patients every day. In very few of those encounters do patients receive substandard care. Mary and I, not medical malpractice, represent the norm. Patients in this country receive the best medical care in the world. This care is being jeopardized by the liability crisis. I urge you to take action to resolve this crisis.

I thank you for this opportunity to discuss my perspective on this important issue. Mrs. Sacco, Mary, or I will be happy to answer any questions you may have for us.

Mr. RYAN. Thank you, Dr. Rockett.

I would just like to ask you a few questions. If you were to have to relocate and it became necessary to find another expert with your qualifications to help treat Mary, what would that entail, and is it possible to achieve that?

Dr. ROCKETT. From an egotistical sense, I hope, I would like to say not. However, I am sure there are other well-trained neurosurgeons. And if it involved only one patient, certainly others who remained behind on the faculty of the university would probably be able to absorb an increase in the practice load.

However, if all of the community-based neurosurgeons were forced out of practice, and the university-based, salaried neurosurgeons were expected to carry or pick up that load, it would not have been possible.

Even as it is in Massachusetts, many of the neurosurgeons are practicing a type of claims management by referring high-risk patients into the university, and that is putting a serious strain on their ability to handle the load already.

Mr. RYAN. How urgent is this problem in terms of its need for attention?

Dr. ROCKETT. It is extremely urgent. I think it is one of the most pressing problems in health care delivery.

Mr. RYAN. Thank you.

Mary, Mrs. Sacco, Dr. Rockett, we want to extend a particular thank you so much for coming here. I am sure it was not easy. But we feel that your testimony is quite crucial to solving what we also consider to be an immediate problem and that needs that kind of attention, and we do appreciate your testimony.

Thank you very much.

Mrs. SACCO. Thank you.

Miss SACCO. Thank you.

[Responses of Anne Sacco to questions submitted by Senator Kennedy follow:]

17 Garfield Road
Milton, MA 02187
September 24, 1986

Mr. Orrin G. Hatch
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Hatch:

Thank you for your recent note and transcript of our testimony to the Senate Committee on September 11, 1986. Mary and I were happy we could give this time and, hopefully, it will prove to be beneficial to the legislation for malpractice insurance reform.

Following is my response to the three questions submitted by Senator Kennedy:

1. I am pleased that something has been done to make it possible for Dr. Rockett and other physicians to remain in practice in Massachusetts. I trust further reforms will be forthcoming so that Massachusetts may retain its excellent standard of medical practice.

2. Yes, I am in touch with several parents of handicapped childre, such as myself, who are very concerned that their doctors will find it necessary to leave Massachusetts.

3. I have spoken with many families and physicians to emphasize the need of federal legislation to curb the rising costs of malpractice insurance.

Once again, thank you, and I would appreciate being kept informed about any further legislation which may be effected in this regard.

Sincerely,

Anne J Sacco

Mr. RYAN. Our fourth panel is made up of Charles Forbes, a senior partner in the Los Angeles law firm of Musick, Peeler & Garrett, and Mr. Frank P. Wilton, chairman of the Health Industry Manufacturers Association.

Mr. Forbes, would you proceed, please?

STATEMENTS OF CHARLES F. FORBES, ESQ., SENIOR PARTNER, MUSICK, PEELER & GARRETT, LOS ANGELES, CA; AND FRANK P. WILTON, CHAIRMAN OF THE BOARD, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION, WASHINGTON, DC, ACCOMPANIED BY TED MANNEN, GENERAL COUNSEL

Mr. FORBES. Yes, Mr. Chairman—is it proper to call you "Mr. Chairman"?

Mr. RYAN. Not really, but proceed.

Mr. FORBES. It is a pleasure to be here. I am general counsel for the California Hospital Association, and we have submitted a paper authored by my partner, Mr. Jim Ludlam, concerning the evaluation of the California experience with the Medical Injury Compensation Reform Act of 1975, which is sometimes referred to as "MICRA", sometimes also referred to as "AB-1-XX". This paper is a very comprehensive analysis of the impact of the various provisions of that act.

I will not go through the paper line-by-line, but I would like to highlight certain of the material in the paper that I think is relevant and is responsive to some of the questions that I think were raised earlier in the questions submitted to Secretary Bowen.

In the first place, I would like to call to your attention that within this paper there are three charts. One is the number of claims reported per 100 beds in the California Hospital Association Group Insurance Program between the years 1970 and 1986 on a year-by-year basis.

The second chart is the average cost per claim for the same period of time on an annual basis.

The first chart refers to the frequency of the claims, the second chart refers to the severity of the claims.

The third chart is the premium paid for insurance per bed for the 1972–86 period.

And finally, there is a table showing a combination of the three charts.

It must be recognized that this material was taken both before the crisis occurred in California and for the years subsequent to the crisis, where the legislation, as you recall, was enacted during the year 1975. So we have statistics from before and statistics from afterwards, and you can use this material to evaluate at least in part the impact.

The table that is also included involves the rates. It is a three-way table, in effect. It shows that the rates for primary coverage per occupied bed went from $23 and some-odd cents per bed, per month, to $219 per bed, per month, during the course of this 15- or 16-year period.

The claims reported, the frequency, went from 3.43 to 11.65, or 25, in 1986, an average growth of 6.2 percent per year. The average cost per claim went from $5,953 in 1970 to $40,000 estimated in 1986, at an average rate of increase of 15 percent per year.

The combined increase between frequency and severity was in excess of 22 percent average for each year during the course of this period.

Now, this information is really not a fair evaluation of the impact of the Medical Injury Compensation Reform Act that I will get into in a few minutes.

However, it is as compared to the other States, an indication that Califorpia has by and large fared better in terms of the rate of increase than other States that do not have legislation similar to MICRA. It is also even more impressive in view of the fact that during the period of time between the day MICRA was enacted and became effective in California, it took close to 8 years for the courts to finally rule on the constitutionality and validity of the various provisions of MICRA. And it was only after that time that defense counsel would fully utilize and implement the benefits that were contained in MICRA insofar as the protection and savings devices that were avaliable.

So it is yet to be determined how effective MICRA is and will be in connection with the future of the malpractice problem as it exists in the State of California.

I would like to mention one other point that tends to diminish the impact of MICRA. In California we have an exciting and an imaginative judiciary. The judiciary has managed to expand by judicial fiat the area of tort liability within the State of California to dimensions that are unprecedented, in my opinion, in other States.

As part of the paper, we have provided you with a summary of the cases in which the judiciary has seen fit to do this, and this has tended, really, by the creation of additional areas of tort liability which can be imposed on the, quote, "malpractice defendant", to diminish the total impact of MICRA.

Now let me make some observations about MICRA itself. It dealt with reforms, but as the Secretary mentioned, and the Senator mentioned, there is no piece of legislation that can deal solely with reforms without also trying to cure the basic problem, and that is get rid of the cause of the bad outcome in terms of hospitalization or medical care and treatment. So I believe any type of legislation has to deal with problems that will improve the quality of care that is rendered in an institution by physicians or practitioners of the healing arts.

I think loss prevention is a serious and vital ingredient to any such piece of legislation, and I hope that whatever is generated, if anything is to be generated, it will include not only reforms, but added measures whereby the source or the cause of the problem can be reduced or hopefully, eliminated.

Let us now look at the various areas of tort reform contained in MICRA and try to evaluate its impact to date.

I believe that the most important of all of the reform measures is the collateral source rule, which was modified in the California statute. There are two ways to modify it. One is to allow the collateral source to constitute a direct set-off against the judgment; the other, which was adopted in California, was to permit the introduction of evidence of collateral source compensation for the jury so that the jury or the judge can take it into consideration in making the final award.

It is estimated that since enactment, this has produced approximately a 20-percent reduction in liability awards as a result of the jury's interpretation of and knowledge of outside collateral source payments.

The second, and I believe the second in importance in terms of the reforms, was the periodic payment. This particular provision under the California law authorizes the payment of future damages and awards exceeding $50,000 over a period of time. This can be funded by an annuity by the insurance company, and therefore they are not expending the whole amount of the judgment at any one given time; they are paying much less than what the judgment might be, and the patient or plaintiff is further protected in connection with the receipt of the annuity, which guarantees for the lifetime of that patient or the lifetime of the award, the amounts contemplated by the award or the judgment. It has been a very effective tool in California, not only in terms of the judgments, but also in terms of encouraging structured settlements, which are generally accepted and used in California and are favored by many of the plaintiffs 'malpractice attorneys, I might add, and I suspect that probably might well be favored by malpractice attorneys in the future if the tax bill goes through as it is, because it would be a great substitute for 401(k).

The next and probably most highly disputed provision of our Reform Act was the limit on noneconomic damages to $250,000. This was contested bitterly by particularly the Trial Lawyers Association out in California. It has been the subject of legislation to repeal it in all of the sessions virtually since it has been enacted. It was attempted to be included in an initiative to be submitted to the voters in California in November, which failed. Each of the pieces of legislation has failed; it has not been modified during the entire 10 years it has been in effect, and there are those that feel that $250,000 is too low and should be modified to be revised upward and perhaps indexed to inflation over a period of time so that people do not have to come back to the legislation each year in order to get an appropriate modification.

I suspect that at one time it will be modified, and I suspect that at one time it will be indexed. It has apparently reduced recoveries anywhere from 10 to 20 percent. There is one case where there was a very dramatic reduction of about $5 million in terms of the verdict.

The contingency fee limitations, which was also bitterly opposed by the Trial Bar in California, is another provision of our MICRA. It does limit the attorneys' contingent fees on a sliding scale. It has been effective to a certain extent in reducing judgments, and in the paper there is an example that I call your attention to, which shows how the plaintiff really ultimately benefits as a result of the combination of the limitation on noneconomic damages and the contingency fee limitation.

One of the more important provisions in our law is the clarification and modification of the statute of limitations which in effect has made insurance more available and more affordable in California. We had virtually an open-ended statute of limitations with respect to minors. They have now reduced this to more of a time-certain, and they have limited the areas in which any tolling can occur to very restricted areas, so this has been a very helpful provision in securing insurance both within the State. And our excess market is primarily over in the London market, and they are very much interested in seeing to it that there is some close in connection with the claims process.

Another provision is arbitration. It is permitted as an alternative dispute resolution process. I do not believe that this has been greatly utilized in California, and one of the problems is if it is used by a hospital, it is not used by a physician, or if it is used by a physician, it is not used by a hospital. And unless you have all parties in connection with the malpractice claim committed to arbitration or committed to litigation, it is not going to work, so they generally go into litigation. Unfortunately, arbitration, I think, was a useful tool, but it has not been used.

Probably the least important of all of our provisions is the notice of intent to sue. That requires an attorney to file a notice of intent to sue prior to filing the claim or the complaint, and during that 90-day period, he is supposed to negotiate the possible settlement. This has been ignored by the trial bar. The California State Bar Association was urged in the legislation to enforce it, and the State Bar Association has refused to enforce it. So it really is sort of a useless provision in connection with the legislation.

Incidentally, I should also add that in terms of the legislation, the attorney contingent fee relates to the plaintiff. The California State Bar Association was requested to do a study on limiting in some way defense counsel fees. They were supposed to report back to the legislature sometime 2 years following enactment of the legislation, which would have been sometime in the year 1977 or 1978, and they have failed or refused for some reason, it is my understanding, to report back at all concerning that potential factor. And we are going to ask them once again to consider this and report to the legislature in some way to reduce or get a handle on defense counsel fees, because they are going up dramatically.

The only additional tort reform measure that has been enacted in California is the one approved by the voters just last June, which was a modification, and it was overwhelmingly approved by the voters, an initiative measure, which was an overwhelming approval of the modification of the joint and several liability doctrine by limiting its applicability to economic damages.

I think any tort reform measure that is adopted, either Congress' guidelines to the States or by the individual States, should consider the joint and several liability issue and should also consider the issue of punitive damages. Punitive damages in many States cannot be insured against, and it is a real problem because it is invariably alleged in the complaint, irrespective of any basis for it, and it is done out in California, where it is not clear as to what criteria can be used to determine what and in what instances punitive damages can be imposed.

I guess I have run over, and I apologize, Mr. Chairman.

Mr. **Ryan**. Thank you, Mr. Forbes. I appreciate your testimony.

[Responses of Mr. Forbes to questions submitted by Senator Kennedy and additional material submitted for the record follow:]

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September 25, 1986

The Honorable Orrin G. Hatch,
Chairman
United States Senate
Committee on Labor and Human Resources
Washington, D.C. 20510

Dear Senator Hatch:

I received your letter of September 18 in which you enclosed the transcript of my testimony together with certain questions posed by Senator Kennedy. I am returning the transcript and will attempt to answer Senator Kennedy's questions by stating the question and then submitting the answer.

Question #1

You've stated that many of the provisions of the California Medical Injury Reform Act have not been implemented, yet you also make estimates as to the impact of these reforms, and specifically you state "our premiums are at least 40% less than they would have been without MICRA" (the reform act). I would be interested to know the data which you used to arrive at this conclusion?

Answer

For many years the California Hospital Association has endorsed a group professional liability insurance program which has been underwritten by Truck Insurance Exchange which is a reciprocal and part of the Farmers Insurance Group. The program has been in effect since the early 1950's and although it has changed over the years it still insures a substantial majority of the acute general hospitals that are currently operating in California. The source of the information used to arrive at the conclusion set forth above was information received from actuaries involved with the professional liability insurance program as well as representatives of the broker involved in negotiating the excess insurance coverage in the London market.

In addition, you will find enclosed two charts on Medical Malpractice Verdicts Average Plaintiff Award trends comparing national with California results, together with the May and June 1986 reports of the Civil Justice Round Table of the Institute for Civil Justice.

Question #2

In your testimony, you state that the arbitration provision has been meaningless, yet in your conclusions you state that you anticipate an expansion of the use of arbitration as an alternative method for resolving disputes. Again I'm concerned about your data?

Answer

As legal counsel to the California Hospital Association we participated in the establishment of voluntary arbitration programs in over 100 hospitals in this state in the early 1970s. As the result of a series of decisions by our appellate courts refusing to enforce the arbitration agreement the number of participating hospitals has been reduced to almost zero. On the other hand, the Kaiser Permanente Health Care Plan, the largest HMO in the nation and the owner and operator of many hospitals in California, has effectively used arbitration for medical malpractice cases for many years and because the arbitration clause is a part of the arms length negotiation between employers and the HMO the California courts have enforced the agreements. The CIGNA Insurance Company, which has acquired the Ross-Loos HMO which used arbitration as a part of the HMO insurance procedure in California, reports it will expand the plan to other states. As we stated in our prepared testimony, we anticipate that other alternative delivery plans, such as PPOs, IPAs and the like, will soon adopt the arbitration approach to dispute resolution.

Question #3

You also advocate in your testimony that we need generic tort reform which applies to all businesses. What basis would you have for including malpractice insurance with no fault auto insurance?

Answer

I do not recall stating in my testimony that malpractice insurance should be included with no fault auto insurance. The thrust of my testimony was that to be truly effective, generic tort reform must apply to the entire liability field which has been, or is now, covered by insurance. Since we do not have no fault auto insurance in California we have no familiarity with it. In some respects no fault auto insurance is like workers compensation insurance, really a specialized form of tort reform.

Question #4

In your testimony you advocate federal regulation of insurance companies if they continue to function in an inept manner. What types of federal regulations do you envision?

Answer

To the extent that I may have advocated federal regulation of insurance companies, I intend to do so only to the extent that federal regulations would assure adequate capitalization and hopefully avoid company failures which must then be picked up by other carriers to the added detriment of the premium paying public.

From the viewpoint of the insureds that we represent, federal regulation could encourage uniformity of coverage, better understanding of premium determination and broader use of experience factors. Very frankly, we do not find that the types of reports available through the states are very informative in determining whether our clients are being appropriately charged.

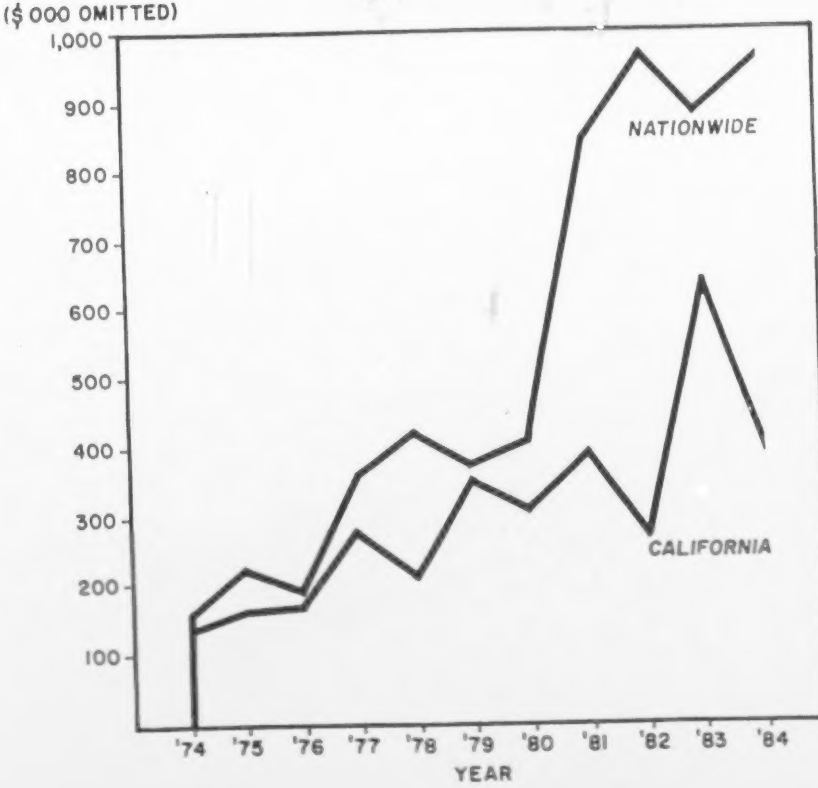
I very much appreciate having had the opportunity to testify before the Committee and will be more than pleased to provide any more information desired by the Committee.

Very truly yours,

Charles F. Forbes
for MUSICK, PEELER & GARRETT

CFF:bh
encs.

MEDICAL MALPRACTICE VERDICTS
AVERAGE PLAINTIFF AWARD



Source: Jury Verdict Research, Inc. (National Data)
Insurance Information Institute (California Data)

MEDICAL MALPRACTICE VERDICTS
AVERAGE PLAINTIFF AWARD

	A	B	
	NATIONAL	CALIFORNIA	B/A (%)
1974	$166,165	$133,817	80.5%
1975	220,018	152,970	69.5%
1976	192,344	166,582	86.6%
1977	364,396	272,311	74.7%
1978	419,372	200,998	47.9%
1979	367,319	351,569	95.7%
1980	404,726	308,682	76.3%
1981	850,396	395,163	46.5%
1982	962,258	257,222	26.7%
1983	888,285	649,210	73.1%
1984	954,858	396,662	41.5%

Source: Jury Verdict Research, Inc. (National Data)
Insurance Information Institute (California Data)

EVALUATION OF CALIFORNIA EXPERIENCE WITH THE MEDICAL INJURY COMPENSATION REFORM ACT OF 1975 (MICRA)

by

James E. Ludlam, Partner
Musick, Peeler & Garrett

Senior Counsel to the California Hospital Association
Member of Secretary's Commission on Medical Malpractice 1971-1973
Member of American Bar Association Medical Professional Liability Commission 1976-1980
Member of American Hospital Association Medical Malpractice Task Force 1985-
One of principal draftsmen of the MICRA
Legal Advisor to the California Hospital Association and its members on malpractice insurance and tort reform issues 1950 to present time
Association members presently spend substantially in excess of $300,000,000 per year in liability insurance premiums.

INTRODUCTION

Any responsible evaluation of a tort reform package or its individual components must be based upon a set of goals designed to create an ideal compensation system. Each proposal should then be valued as to how it contributes to achieving those goals.

The ABA Medical Professional Liability Commission, in its Interim Report to the ABA House of Delegates, published September 27, 1976, published a set of goals as stated on page 10 of said report.

> ". . . It early agreed that its paramount consideration must be the needs of patients as a class and has considered in some depth the goals an ideal compensation system ought to have and how such a system ought to relate to efforts to prevent adverse incidents. These goals, which have guided the Commission, are to:
>
> 1. Encourage the prompt availability of remedial medical services to injured persons;

2. Compensate all persons deemed compensable under the mechanism;

3. Pay a victim of a compensable medical incident at least the net economic loss occasioned by that incident;

4. Provide for the prompt resolution of claims;

5. Charge a minimum of administrative costs (including attorneys' fees) and make a maximum amount available for the injured person;

6. Insure maximum predictability of outcome as an aid to planning by health care providers and insurers;

7. Discourage the bringing of baseless or contrived claims and provide for their prompt elimination if brought;

8. Contribute to the prevention of malpractice incidents by introducing incentives for improving health care and for improving the supervision and discipline of health care personnel;

9. Distribute losses, through insurance or otherwise, in a way which does not leave an unfair burden on any one segment of the health care system; and

10. Disrupt to the least possible degree the relationships of trust and confidence between health care providers and patients."

The California legislative reaction to the crisis of 1975 was embodied in a comprehensive package of legislation that was directed not only to a significant modification of the tort system as applied to medical malpractice but, also, dealt with the roles of the other affected parties, including the health care providers, with strengthening of licensure and disciplines, the role of the insurers, the compensation of both plaintiff and defense counsel, and the encouragement of arbitration as an alternate method of dispute settlement.

Since the legislation was limited solely to the medical malpractice problem it was subject to immediate and fundamental challenge that it violated the equal protection clauses of both the State and Federal Constitutions as well as certain specific challenges to particular provisions of the Act. Although repeated efforts were made to obtain State Supreme Court rulings on these key constitutional questions, it was not until the decision in the American Bank & Trust Co. v. Community Hospital case, by a four-to-three decision in 1984, that the Act was held to be constitutional on equal protection grounds. 1/

During the entire ten-year period the ability to effectively implement the Act in accordance with its intent was spotty to say the least. There was no uniformity in the decisions of either the trial courts or the intermediate courts of appeal. For this reason it is not now possible to statistically evaluate either the package of reforms or the individual provisions. However, insofar as the cost and the continued availability of liability insurance to both physicians and hospitals not only after the crisis in 1975 but continuing through to the present time are concerned, the results are dramatic particularly as contrasted with the experience in other states which achieved little in the way of effective change, either through the reluctance of the legislature or the adverse decisions of the courts on constitutional issues. Attached to this statement as Appendix 1 is a schedule showing what happened to hospital malpractice premiums during the period 1970 through 1986 with an analysis of what occurred. Included with this appendix are also charts showing the pattern of the frequency and severity of claims during this period. Using 20-20 hindsight these charts provide a wealth of information of what can occur during a crisis and with corrective legislative action.

The California experience must be evaluated in the light of the continued pattern of liberalization of the tort law at a breakneck pace during this entire period. For this reason even comparing 1986 results with 1975 results is a matter of comparing apples and oranges. Although a legislature may subject its actions to periodic reevaluation, it is readily apparent that the courts are never prepared to do so--but duck the consequences by saying it is now a matter for legislative action. The California Court has to a substantial degree preempted the role of the legislature in the field of tort law, with the exception of MICRA which took a health care crisis to bring about action. Attached to this report as Appendix 2 is a brief summary of the actions taken by the courts of California to expand the tort

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1/ American Bank & Trust Co. v. Community Hospital, 36 Cal.3d 359, 204 Cal.Rptr. 671, 683 P.2d 670.

system during this period of time. As shown by Appendix 1, the accumulation of these actions has not only substantially offset the positive impact of MICRA but if the pattern continues we can expect another crisis in California in the near future.

The only major legislative development since the 1975 action was the refusal by the 1985 legislature to modify the Supreme Court decisions adopting the deep pocket concept of joint and several liability to all torts along with any other substantial tort reforms that were presented to it during this ten-year period. Following the legislature's refusal to act on the joint and several problems an initiative was circulated in 1986 which proposed to modify the court rulings on joint and several liability insofar as it applied to non-economic recovery as to all torts, not just medical malpractice. The initiative was overwhelmingly approved by the voters and is now in effect. This is a strong indication of the attitude of the general public on tort reform issues and which is clearly not reflected by either the California courts or the legislature. In my judgment this experience as well as what has happened in other states is a clear indication that there will be no nationwide move toward effective tort reform without definitive action by the Congress.

With this background in mind let us now proceed to consider certain of the key concepts of MICRA and their apparent result in California.

CHANGE IN THE COLLATERAL SOURCE RULE

No aspect of the tort system more clearly highlights the inequities of the present tort system than the existence of the court-created collateral source rule generally in effect in nearly all states.

Under this concept the defendant is prohibited from introducing in evidence facts establishing that certain elements of economic loss claimed by the plaintiff have already been covered no only once but often several times by payment by or from other or "collateral" sources.

What we find when we study the underlying basis for the rule is that as a part of our social insurance system there is a broad mosaic of mechanisms designed to protect the individual from economic loss from whatever source, including possible medical malpractice. In other words, these mechanisms are by and large no-fault devices such as health insurance and disability insurance that are payable regardless of the source of the injury with or without fault and clearly overlap or duplicate the recovery under a tort claim.

Of critical importance from the viewpoint of the goals stated in the introduction these mechanisms are prompt, provide full or substantial compensation, have a minimum of administrative cost and are predictable.

One of the major sources is health insurance in all of its many forms, including Medicare, Medicaid, basic health insurance such as commercial coverages, Blue Cross, Blue Shield and the new alternatives such as HMOs, EPOs and PPOs, and personal policies. In addition, similar benefits are included under workers' compensation coverage and various endorsements to auto, homeowners, life and other forms of insurance. Many state and federal programs provide for broad government-financed programs for crippled children, the handicapped and other rehabilitation services.

From the viewpoint of public policy these resources are efficiently and effectively distributed for the benefit of the injured. Many of these policies or programs result in 90% or more of the premium or appropriation resulting in direct service to the individual as distinguished from the inefficiency of the malpractice system that results in only 25% to 40% of the premium resulting in direct benefits to the injured party.

As a part of the vicious cycle involved in the current funding method is the fact that the provider cost of malpractice insurance is directly reflected in the cost of these collateral sources. Not only are the direct costs of malpractice premium reflected in health care costs but also the much larger indirect cost of defensive medicine. Although the cost of defensive medicine is difficult to quantify, my own 45-year experience in the health care field would indicate that the annual tab of $16 billion estimated by the AMA is probably on the low side.

There are two basic approaches to modifying the collateral source rule. The first is simply to eliminate it entirely and thus require the direct offset of the collateral sources received by the plaintiff. This is the most effective.

The second alternative is that followed in California which was to permit the jury to receive evidence of the collateral sources but not be required to directly offset the amounts received by the plaintiff. This was a legislative compromise and one which we found to be acceptable as a part of the total package.

The MICRA provision modifying the collateral source rule appeared in a new Section 3333.1 to the California Civil Code, providing:

> "(a) In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable a a benefit to the plaintiff as a result of the personal injury. . . . Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence.
>
> "(b) No source of collateral benefits introduced pursuant to subdivision (a) shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant." 2/

As previously stated and as will be explained, it is difficult to quantify the amount of reduction of recoveries resulting from this section. However, I would estimate that it runs between 10% and 20% of total potential recoveries with the odds being on the larger percentage.

We have found that even the evidentiary rule has several identifiable impacts upon awards and settlements. First is a threshold effect. A trial attorney reviewing a prospective case as a threshold matter is particularly concerned with the provable economic losses as a base for his case and for estimating the total potential recovery. If the special damages have been substantially covered by collateral sources the case may never be brought or, if brought, a quick settlement is sought. Although nearly nine out of ten cases of liability are settled, the results of the one out of ten that are tried constitute the base line for the settlement of the other nine.

In the second place, in certain types of cases in which there are potentially catastrophic damages (as in an infant brain damage case) but the case is weak on liability, as is often the situation, the plaintiff's attorney must truly prove his liability case instead of relying on jury sympathy for the economic burden on the plaintiff or plaintiff's family which has, in fact, been covered by collateral sources.

2/ Held constitutional in Fein v. Permanente Medical Group, 38 Cal.3d 137, 211 Cal.Rptr. 368, 695 P.2d 665 (1985), *hearing den.* by U.S. Supreme Court.

Double or multiple recovery for the same loss is not in accordance with the historical concept of insurance. The earliest insurance coverage was for fire and marine risks and it was considered against social policy to permit double recovery for the same loss no matter how many insurance policies the insured may have paid for. As applied to the collateral source rule, one argument against the change is that if the plaintiff has prudently purchased insurance he should get the product of his bargain and not benefit the negligent health care provider. It is doubtful that he bought the insurance for that particular loss but, in any event, he should be given reasonable credit for any premium he may have paid for such purpose. A good example of the change in public policy on the matter of duplicate coverage or payment has occurred in the field of health insurance. In the early development of health insurance there was no provision for preventing multiple recovery under duplicating or overlapping policies. As insurers and government became concerned by the added cost of multiple insurance, states first permitted carriers to provide for coordination of benefits and then mandated it under certain circumstances. Now coordination of benefits is the rule. Under Medicare there are now provisions that specifically require that Medicare payments are only to be paid after application of employer group coverage.

An additional problem arises if the collateral source seeks to subrogate its benefit paid to the plaintiff against the malpractice liability defendant. Again, as part of social policy of funding the loss in the most efficient way, the right of subrogation should be prohibited for all the reasons previously discussed. 3/

Although other experts may disagree, it is the opinion of the writer that of all the tort reforms achieved under MICRA this is not only the fairest but the most effective.

PERIODIC PAYMENT

Although simple in concept, the requirement that awards over a fixed minimum for future losses, including pain and suffering, be paid on an installment basis over the life of the defendant and, to the extent the award is for care or support of dependents for the period of dependency, is one of the most complex to draft and implement.

3/ Subrogation provision held constitutional in Barme v. Wood, 37 Cal.3d 174, 207 Cal.Rptr.3d 920, 695 P.2d 164 (1985).

We had had some minimal experience with what was known as structured settlements which were developed by some innovative insurance executives but as far as we could determine there had been no previous effort to require such a methodology by statute. Both the Secretary's Commission and the ABA Commission had recommended the approach without attempting to refine the concept.

The particular provision for this concept included in MICRA was the addition of a new California Code of Civil Procedure Section 667.7, providing:

> "(a) In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. . . .
>
> "(b)(1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor. . . .
>
> "(c) However, money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his death. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

> "(d) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease. . . .
>
> "(e) As used in this section:
>
> "(1) 'Future damages' includes damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.
>
> "(2) 'Periodic payment' means the payment of money or delivery of other property to the judgment creditor at regular intervals." 4/

Our language was a pioneering effort in draftsmanship and I am sure with ten years of actual experience the provisions could be materially improved upon.

Under a lump sum judgment the amount granted by the jury might be more or less than the amount needed to provide for the jury-determined needs of the plaintiff. Furthermore, since the jury would seek to protect the plaintiff for normal life expectancy, there was the potential of major windfalls for the heirs of the plaintiff. There was also concern for the potential dissipation of the lump sum judgment that was needed to provide for the needs of the plaintiff. Through the use of annuity funding the needs of the plaintiff could be covered for life regardless of how short or long with appropriate provision for inflation. In other words, the award could be designed to meet the needs of the plaintiff.

Our experience would indicate that one of the chief benefits of the periodic payment provisions in MICRA is that it has made the use of structured awards an accepted and preferred method of negotiating settlements. Proficient experts have evolved for both the plaintiffs and defendants and some really creative arrangements have been negotiated for the benefit of all concerned. Although some of the publicity around some of these settlements would indicate that the ultimate pay-out of these awards could be astronomical, in fact these guaranteed payments

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4/ Held constitutional in American Bank & Trust Co. v. Community Hospital, 36 Cal.3d 359, 204 Cal.Rptr. 691, 687 P.2d 670 (1984).

can be funded at a substantial savings in cost as contrasted with the lump sum method. We even find that some plaintiffs' attorneys are taking their fees in a structured form, particularly late in the tax year. We may assume that under the new tax reform package plaintiffs' attorneys will use the periodic payment provision as a substitute for the cutback in their 401K plans.

Care must be used in drafting the statutory language to be sure that it provides for what is, in effect, an annuity and not an installment payment award with accruing interest on the deferred balance. We believe this approach substantially meets the ABA criteria.

STATUTORY LIMIT ON DAMAGES FOR PAIN AND SUFFERING OR NONPECUNIARY LOSS

One of the key sections of MICRA was the addition of California Civil Code Section 3333.2, providing:

> "(a) In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.
>
> "(b) In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000)." 5/

Although the impact of this section on our total experience is difficult to quantify because the major impact is upon settlements, there have been sufficient dramatic cases where the jury verdict has been reduced by millions of dollars so that it is clear that the overall impact must be between 10% and 20% of the total of potential judgments and settlements.

The basic problem with the concept of general damages is that there is no objective standard against which a jury can be instructed to act in assessing such damages and as a result on occasion, and certainly more frequently in malpractice cases, may grant awards that appear far out of reason as distinguished from

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5/ Held constitutional in Fein v. Permanente Medical Group, 38 Cal.3d 137, 211 Cal.Rptr. 368, 695 P.2d 665 (1985).

the awards granted for comparable injuries in other tort actions. Unfortunately, neither the trial courts nor the appellate courts have seen fit to exercise effectively their authority in moderating the aberrational awards. The fact that these awards exist only encourages plaintiffs to gamble on the potential for their own recovery and by being encouraged by their own counsel who compete in the competitive awards game. Since the defendants must consider this potential in any settlement negotiation it becomes a substantial factor in evaluating cases that may be weak on liability but strong on emotional appeal. The current experience with the infant brain damage cases is a perfect example of this syndrome.

Although some experts predicted that the establishment of a ceiling on pain and suffering would establish a floor as well as a ceiling, this has not been the California experience.

LIMITATION ON CONTINGENCY FEES

Under Section 6146 of the California Business and Professions Code limitations were placed upon the contingency fees that could be charged by plaintiff's counsel. The language provides that:

> "(a) An attorney shall not contract for or collect a contingency fee for representing any person seeking damages in connection with an action for injury or damage against a health care provider based upon such person's alleged professional negligence in excess of the following limits:
>
> "(1) Forty percent of the first fifty thousand dollars ($50,000) recovered.
>
> "(2) Thirty-three and one-third percent of the next fifty thousand dollars ($50,000) recovered.
>
> "(3) Twenty-five percent of the next one hundred thousand dollars ($100,000) recovered.
>
> "(4) Ten percent of any amount on which the recovery exceeds two hundred thousand dollars ($200,000).
>
> ". . . The limitations shall apply regardless of whether the recovery is by settlement, arbitration, or judgment, or whether the person for whom

> the recovery is made is a responsible adult, an infant, or a person of unsound mind.
>
> "(b) If periodic payments are awarded to the plaintiff pursuant to Section 667.7 of the Code of Civil Procedure, the court shall place a total value on these payments based upon the projected life expectancy of the plaintiff and include this amount in computing the total award from which . . . attorney's fees are calculated under this section." 6/

At this point we can report very little evidence of results from this section because the attorneys for plaintiffs completely flaunted it up to the time of the refusal of the United States Supreme Court to hear their petition challenging the constitutionality of the California statute. As a result there are literally hundreds of millions of dollars in illegally collected contingent fees being retained by attorneys. In view of the continued attitude of both the American Bar Association and the California Bar Association on the subject of tort reform it is not surprising to report that the California Bar Association has done nothing to protect clients from the practice of plaintiffs' attorneys ignoring this fee limitation nor, now that the statute has been ruled constitutional, made any effort to require restitution to the clients who have been illegally charged over the past ten years. This only highlights the potential conflict of interest between an attorney and his client under a contingency fee arrangement.

For the future we anticipate a substantial impact upon the cost of settlements for malpractice cases, particularly when combined with other provisions of MICRA.

The following example will highlight the interrelationship between the limitation on contingent fees and the limitation of $250,000 on pain and suffering under MICRA.

> Assume a $1,000,000 judgment split 50/50 between economic and non-economic losses.

6/ Held constitutional in Roe v. Lodi Medical Group, 37 Cal.3d 920, 211 Cal.Rptr. 77, 695 P.2d 164 (1985).

Without MICRA and assuming the pattern of 40% contingent fee for malpractice cases, the result would be:

Attorney $400,000 Plaintiff $600,000

Under MICRA the result would be $500,000 judgment for pain and suffering reduced to $250,000. The statutory attorneys' fee would be:

40%	x	$50,000	$ 20,000
33-1/3%	x	$50,000	16,666
20%	x	$100,000	20,000
10%	x	$550,000	55,000
Total attorneys' fees			$111,666
Net to injured plaintiff			$638,334

One of the principal claims made by the leaders of the plaintiff's malpractice bar in challenging the constitutionality of the MICRA limits on contingent fees was that it deprived plaintiffs of the right to be represented by competent counsel (as they identified themselves). In addition, these attorneys, by affidavit filed in the California Supreme Court, stated that if the constitutionality of the limitation was sustained they would not accept future medical malpractice cases. Either their memory is very short or their affidavits were not made in good faith as these same attorneys have continued to file medical malpractice cases in almost an equal volume as before. We can only assume that it is the injured plaintiffs that are benefitting from this limitation.

As a matter of fairness we must assume that the amount of the ultimate judgment has far more to do with the injury to the plaintiff than it has to do with the skill of the attorneys.

The limitation on contingent fees appeared to meet the ABA Commission criteria.

STATUTE OF LIMITATIONS

The existence of a rational statute of limitations is a component in assuring the continued availability of liability insurance for health care providers. Tort actions by or on behalf of minors creates a very special problem in the health field.

At the present time the frequency and severity of claims relating to alleged birth injuries is the number one medical problem. This is a relatively new development as only a few years ago those babies did not survive. However, with the major advances in neonatal care, children with monstrous physical and mental problems survive. The treatment problems are so complex and occur under such extreme pressure that there is a high potential of error. When presented to a jury they have an overwhelming emotional appeal.

Without some effective statute of limitations an insurance carrier may be faced with trying a case more than 20 years after the occurrence and certainly log when the important witnesses are no longer available. Attempting to establish a premium for such risks and the potential of carrying reserves for such unknown claims materially add to the cost of insurance if the carrier chooses to underwrite it at all. Even under a claims-made policy it has a drastic impact on the cost of tail coverage.

Increasingly legislatures have become cognizant of the problem and have attempted to achieve a rational balance between the rights of the infant and the burden upon health care providers and their insurers.

As a part of MICRA the legislature amended a key paragraph of the California Code of Civil Procedure Section 340.5 to provide:

> "In an action for injury or death against a health care provider based upon such person's alleged professional negligence, the time for the commencement of action shall be three years after the date of injury or one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of legal action exceed three years unless tolled for any of the following: (1) upon proof of fraud, (2) intentional concealment, or (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person. Actions by a minor shall be commenced within three years from the date of the alleged wrongful act except that actions by a minor under the full age of six years shall be commenced within three years or prior to his eighth birthday whichever provides a longer period. Such time limitation shall be

> tolled for minors for any period during which parent or guardian and defendant's insurer or health care provider have committed fraud or collusion in the failure to bring an action on behalf of the injured minor for professional negligence."

The section was declared constitutional in 1983 and has been the least controversial section of MICRA. 7/ Without that amendment and with the development of neonatal birth injury claims since then the cost and availability of insurance coverage would have been highly speculative.

Even with the above amendment the cost and availability of insurance for any physician engaging in deliveries has caused a major reduction in such service as a very substantial portion of the practitioners can no longer afford to practice this specialty. This has been particularly tragic for the poor and the near poor as under government programs such as Medicaid the professional fee may be less than the direct cost of insurance for the procedure by the attending physician. The statute of limitations is only a partial answer to this problem.

Furthermore, this particularly highlights the fallacy of dealing with averages. If we assume the average cost of liability insurance may range from 5 to 20% of gross income in the various states, the cost of insurance of the obstetrician will be several times the average.

ARBITRATION

As far back as 1969 California hospitals and physicians had experimented with contract arbitration as an alternative method of dispute resolution. The attempt was made to establish an agreement to arbitrate at the time of admission to the hospital and prior to the rendition of professional or hospital services. Although the courts have declared that the use of arbitration is to be encouraged as a substitute for litigation, this has proved to be only lip service as applied to individual agreements. As a part of MICRA an attempt was made to clarify the issues and validate the procedures being followed. The legislation included a Section 1295 to the Code of Civil Procedure to provide:

7/ Kite v. Campbell, 142 Cal.App.3d 793, 191 Cal.Rptr. 793.

"(a) Any contract for medical services which contains a provision for arbitration of any dispute as to professional negligence of a health care provider shall have such provision as the first article of the contract and shall be expressed in the following language: 'It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.'

"(b) Immediately before the signature line provided for the individual contracting for the medical services must appear the following in at least 10-point bold red type:

"'NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.'

"(c) Once signed, such a contract governs all subsequent open-book account transactions for medical services for which the contract was signed until or unless rescinded by written notice within 30 days of signature. Written notice of such rescission may be given by a guardian or conservator of the patient if the patient is incapacitated or a minor.

"(d) Where the contract is one for medical services to a minor, it shall not be subject to disaffirmance if signed by the minor's parent or legal guardian.

"(e) Such a contract is not a contract of adhesion, nor unconscionable nor otherwise

> improper, where it complies with subdivisions (a), (b) and (c) of this section.
>
> "(f) Subdivisions (a), (b) and (c) shall not apply to any health care service plan contract offered by an organization registered pursuant to Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, which has been negotiated to contain an arbitration agreement with subscribers and enrollees under such contract. . . ." 8/

Unfortunately the courts have continued to follow the pattern of upsetting nearly every arbitration agreement brought before them and as a result the use of 1295 is almost meaningless. However, the courts have sustained malpractice arbitration agreements that have been included in group health insurance policies such as those provided by HMOs even though in those cases the arbitration provision has been approved by the employer rather than the individual. We would anticipate that in the future there will be a considerable expansion of the use of arbitration as an alternative method of resolving disputes. 9/

From the viewpoint of the ABA Commission criteria arbitration has many advantages. It can be speedy, less expensive, less traumatic to the parties and is a process that should assure fairer results.

NOTICE OF INTENT TO SUE

One of the least successful reforms included in MICRA was the requirement of a 90-day notice of intent to sue included in new Code of Civil Procedure Sections 364 and 365, providing that:

> "(a) No action based upon the health care provider's professional negligence may be commenced unless the defendant has been given at least 90 days' prior notice of the intention to commence the action.

8/ Madden v. Kaiser Foundation Hospitals, 17 Cal.3d 699, 550 P.2d 1178 (1976).

9/ Wheeler v. St. Joseph Hospital, 63 CA.3d 345, 133 Cal.Rptr. 775 (1976).

> "(b) No particular form of notice is required, but it shall notify the defendant of the legal basis of the claim and the type of loss sustained, including with specificity the nature of the injuries suffered.
>
> ". . .
>
> "(d) If the notice is served within 90 days of the expiration of the applicable statute of limitations, the time for the commencement of the action shall be extended 90 days from the service of the notice. . . ."

Section 365 provides as follows:

> "Failure to comply with this chapter shall not invalidate any proceedings of any court of this state, nor shall it affect the jurisdiction of the court to render a judgment therein. However, failure to comply with such provisions by any attorney at law shall be grounds for professional discipline and the State Bar of California shall investigate and take appropriate action in any such cases brought to its attention."

The concept of these sections was that by requiring a 90-day notice of a claim there would be a period for investigation and, hopefully, resolution of the claim. Furthermore, the notice was a far less traumatic form of initiating a claim than the filing and serving of a law suit. Our experience indicated in the majority of cases that the first knowledge a physician or hospital has of a claim is the receipt of a summons and complaint which in itself only aggravates a potentially tense situation.

We have seen little positive result from this section by either the plaintiffs' attorneys or the insurance carriers. Furthermore, the State Bar of California has refused to enforce the provision.

ADDITIONAL COMMENTS

As the result of MICRA California health providers have continued to be insurable. Furthermore, the best evidence available would indicate that malpractice premiums have increased at a substantially lower rate than in the other states where no comparable reforms were enacted or the reforms that were adopted were gutted by the state courts. Our best estimate is that our premiums are at least 40% less than they would have been without MICRA.

However, it is equally true that even with MICRA, through the action of the courts of California the future liability costs for California health care providers have continued to increase even though at a substantially lower rate than in the other states, and that unless there are further tort reforms in the near future California health care providers may face another 1975 crisis. (See Appendix 1 for further exposition on this point.) Unfortunately, such a crisis could be even more serious because the basic insurance costs are now far higher than in 1974-75 and from the physician side the great bulk of the insurance is with captive companies with only one line of risk and are therefore particularly vulnerable. We believe that these carriers have followed conservative underwriting practices and have good management and since they are controlled by the medical profession they will not panic and withdraw from the market. But that will not moderate the necessary premium increases.

What, then, do we need in California?

We need generic tort reform applying to all of business and society. So long as health providers are treated separately we can anticipate a continued chipping away at the protections we have achieved. The entire tort system must be rationalized or replaced.

In addition to those reforms we have received we need effective action on controlling the problem of punitive damages. In a state in which punitive damages are uninsurable, such as California, the allegation of punitive damages creates an immediate conflict between the insured and the insurer. Also, although the assessment of punitive damages is not frequent, the courts have established no objective standards to be used in imposing such damages or in determining the amount of such damages. A careful analysis of the possible solutions to the punitive damage issue is beyond the scope of this presentation and should be the subject of special legislation, both nationally and at the state level.

Although the voters of California overwhelmingly approved a modification of court-created rule of joint and several liability insofar as it applies to non-economic damages, in the future serious consideration must be given to extending this modification to all damages.

Because of the continued pattern of the courts usurping legislative prerogatives by continuously expanding the tort system the legislatures should take back this authority and clearly delineate the limits of tort liability by defining negligence, causation and damages.

Now that more than ten years have passed since the adoption of MICRA we need to work with the legislature to update the MICRA reforms based upon this experience.

Our basic problem has been that the plaintiff's bar refuses to recognize that there is a problem and with their overwhelming influence on the key legislative committees the change for further constructive action apparently must await the next crisis--a most destructive approach to the legislative process.

Perhaps the problems developing in the cost and availability of legal malpractice insurance will catch the attention of the leadership of the Bar at both the state and national levels. It is interesting to note that in the summer 1986 issue of "The Brief," the official publication of the ABA Tort Insurance Practice Section, that the leaders of that Section are now claiming a crisis, blaming it on the insurance industry and still refusing to acknowledge their own responsibility for the solution. The charts presented in the articles show the same pattern for frequency and severity of claims that we experienced in the period 1970-1976. Apparently the Bar leadership chooses to relive history rather than learn from it.

THE ROLE OF THE INSURANCE INDUSTRY

The insurance industry is now taking a bad rap for its part in the problem. Unfortunately, the insurance industry is the messenger carrying the bad news of premium increases that reflect the underlying problems of the frequency and severity of claims. Attacking the insurance industry does not solve the basic issues.

However, the insurance industry has handled the matter in an extremely inept manner in the failure to explain its role and be forthcoming on the facts. The fear of federal control has led to a completely incomprehensible pattern of regulatory jurisdictions with methods of accounting and reporting that defies rationality. In many respects the insurers are the victims and not the villains but, unfortunately, the conflicting forces within the industry prevent the presentation of a rational case to the public, the purchasers of insurance, or the legislatures including the Congress. Unless they can get their act together they must accept federal regulation.

From the viewpoint of the purchasers of insurance there is also much that can be done. To be financially rational insurance must be purchased in large amounts so that the purchaser can be effectively advised as to costs and terms. Recognition must be given to the fact that an insurance contract should be a partnership between the insured and the insurer for the purpose of solving a problem. If they are inherently adversaries the relationship will fail. It takes time and understanding to develop such a relationship and legislation should encourage that relationship by authorizing, group purchases, pooling and full access to data in an understandable form.

The purchasers of insurance have an important role in risk management and risk prevention. These are quality control issues for which the whole American economy and way of life are being challenged by our foreign competitors.

In the health care field this is particularly important because we are dealing with human life in a high-risk setting. Because of the sheer volume of human judgments that must be made a certain element of human error is inherent in the process. We must take many risks on as a necessary component of health care and the results are not always optimal. Also, as medical care becomes more complex the potential for error increases. For example, birth injuries are now the number one medical malpractice problem but only three or four years ago they were not a major factor because we did not have the capability of saving these babies. The same was true as we went through the cycle of cardiac arrest cases, the retrolental fibroplasia cases, the exchange blood transfusions and the like. Now we face the future potential of hepatitis and AIDS cases, all a part of change that we cannot predict or control.

APPENDIX 1

THE EXPERIENCE OF THE CALIFORNIA HOSPITAL ASSOCIATION GROUP LIABILITY INSURANCE PROGRAM
1970-1986

This exhibit includes three charts showing three different characteristics of the experience of hospitals during this period. Reviewing these charts with 20/20 hindsight makes it possible to learn some very important lessons about how a crisis can develop, how the insureds and insurers react and, most importantly, how difficult it is for an insurance company to prospectively establish a premium with only the current information at hand. The actuaries must rely primarily on the developing information of the past in an attempt to predict trend lines that will converge into reality over a period of six or seven years. Only after the years have passed can you look back and see who won or lost.

Over the long run malpractice premium rates must reflect the results of claims paid multiplied by the cost per claim or, in shorthand, the frequency times the severity. Obviously when both trends are moving in the same direction the impact up or down is a geometric progression. Furthermore, a change in frequency or severity will impact the entire backlog of claims or potential claims going back as much as ten years. For this reason alone any substantial change in either frequency or severity has an impact on future premiums that is far greater than the actual year-to-year increase in underlying experience.

As we look at Chart #1 on the frequency of claims we see that this figure roughly doubled during the period from 1970 through 1974. Since this claims pattern was a trend line for all of those years it meant that the premium would have to more than double or triple to realistically cover future losses for those policy years. Also, as the chart shows, with the adoption of MICRA tort reforms in 1975 the trend stabilized through 1979 when the trend line again began to creep up as the California courts continued to follow the pattern of expanding tort liability concepts as listed on Appendix 2. The percentage increases from 1980 through 1986 are not comparable to the percentage increase from 1970 through 1976 but they were from a higher base and in terms of dollars per bed are equal to the increase for 1970-1974.

Now, if we look at Chart #2, we see the pattern of the average cost per claim proceeded with relative stability for the period 1970 through 1978 and thereafter a gradual increase followed by the dramatic increases through 1986. In other words, the crisis of the seventies was a crisis of frequency and developing for the eighties is a crisis of severity. In any event, it is clear that there is much more to be done in the area of tort reform in California.

Now let us look at Chart #3 which shows the premium per month per bed for the California hospitals through the Association group program. This chart only covers the premium for the first million dollars of coverage, and does not include the excess layers above this.

The first million dollar layer included all of the costs of the program including total defense costs and substantial costs of claims prevention.

Furthermore, commencing with the year 1973 the program for the period through 1979 was operated as a continuing program on a retrospective basis so that underwriting gains and losses were carried through the entire period without cutoff at each annual renewal date. The intent of the program was to establish a premium structure that would be more than adequate with provision that if the premiums over the entire period were redundant they would be returned to the hospitals either in the form of reduced premiums or an ultimate dividend. Under this arrangement the insurance carrier and the Hospital Association worked together on establishing the prospective premiums using the services of three separate actuaries and the most sophisticated current data on claims and losses then available in the country.

Chart #4 shows the same information as shown on Charts #1, #2 and #3 but states the results in dollars for purposes of comparison and further highlights the problem of compounding when dealing with both the severity and frequency issues. From the viewpoint of hospitals that are now being reimbursed on a prospective payment system, the fact that the hospital will have to absorb these future costs is indeed a bleak prospect. The situation is even more critical for the physicians for whom payment under Medicare and Medicaid essentially have been frozen for the last several years.

Significantly the premiums increased from 1974 through 1976 by four times the 1974 premium and for the period 1976 through 1980 premiums were kept level as the parties waited to see the effect of MICRA. By 1980 it was apparent that MICRA had had a very substantial impact upon the total cost of the program and that in hindsight the premiums from 1976 through 1980 were redundant and provided a substantial surplus available for reduction of future premiums or future refund to hospitals. The decision was made to apply the surplus to stabilizing and even reducing the premiums. As it turned out this practice effectively masked the fact that as the result of the application of surplus to current premiums the rapid increase in the cost per claim commencing in 1981 was not being reflected in current premiums, with the end result that when the surplus ran out in 1983 the monthly bed rate had to be substantially increased each year to reflect the underlying experience. It is the belief that current premium increases will be from 15% to 20% and hopefully hindsight in five years will confirm this. This experience reflects the high degree of risk taken by the insurance carrier as well as the critical importance of a long-range group program to adjust to this wide swing in the underlying losses.

Of great importance is the fact that the adoption of MICRA gave hospitals and physicians working together time to engage in a statewide quality assurance and claims prevention program developing reporting mechanisms and early warning systems that are being copied in the rest of the country. However, as frequently stated in our principal presentation, the very nature of the practice of medicine and hospital care is that by its very progress new areas of potential risk are created that inevitably results in increasing imposition of liability under an expending tort system. The risks that are insured in one year are entirely different from the risks insured five years later.

We would also point out that during the entire period from 1970 through 1986 there has been a rapidly increasing pattern of supervision and discipline over individual physicians. Unfortunately, there is a tendency by writers on this subject to rely on the reported disciplinary action by the state medical licensure board, which is known as Board of Medical Qualifty Assurance (BMQA) in California. Looking solely at those figures there is not a major amount of activity as compared to the total number of licensed physicians.

However, what is not generally understood is that the actions of BMQA are only the tip of the iceberg of a very effective review and disciplinary process that affects every physician practicing in a hospital. Peer review voluntary is a process formerly initiated by hospitals and the California Medical Association early in the 1960s and now mandated by the Joint Commission on Accreditation of Hospitals, and more recently by state law as well as by the PSRO and PRO regulations and requirements under Medicare and Medicaid. This type of approach is far more effective than the cumbersome procedures of licensure. Not only do the hospitals, through their medical staffs, maintain profiles on individual physicians but these are reviewed periodically as a part of the renewal process, or if any aberrational behavior develops. Special diversion programs have been developed to deal with alcohol or drug abuse problems.

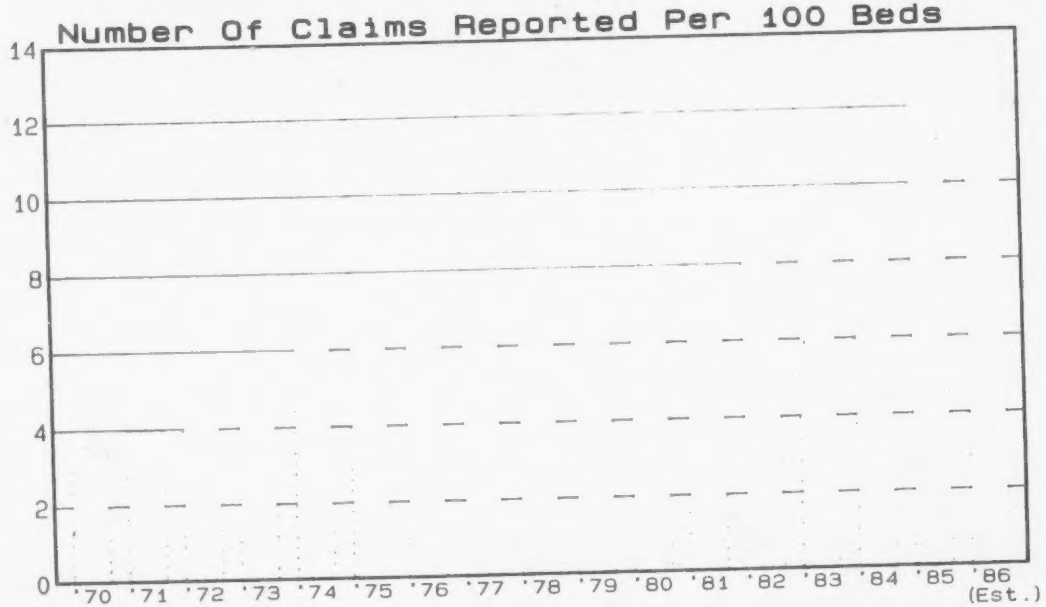
Furthermore, under the new method of payment for hospital services under Medicare, called Diagnostic Related Groups, the hospital must maintain comprehensive records of physician and hospital performance which acts as an early warning system for disclosing substandard practice by either the physician or hospital personnel.

THe importance of these developments is that not only are hospitals and physicians engaged in increasingly sophisticated monitoring and disciplinary activities as well as quality assurance but the liability insurance costs continue their seemingly inevitable increases.

CHART 1

CALIFORNIA HOSPITALS

PROFESSIONAL LIABILITY INSURANCE - 1st MM



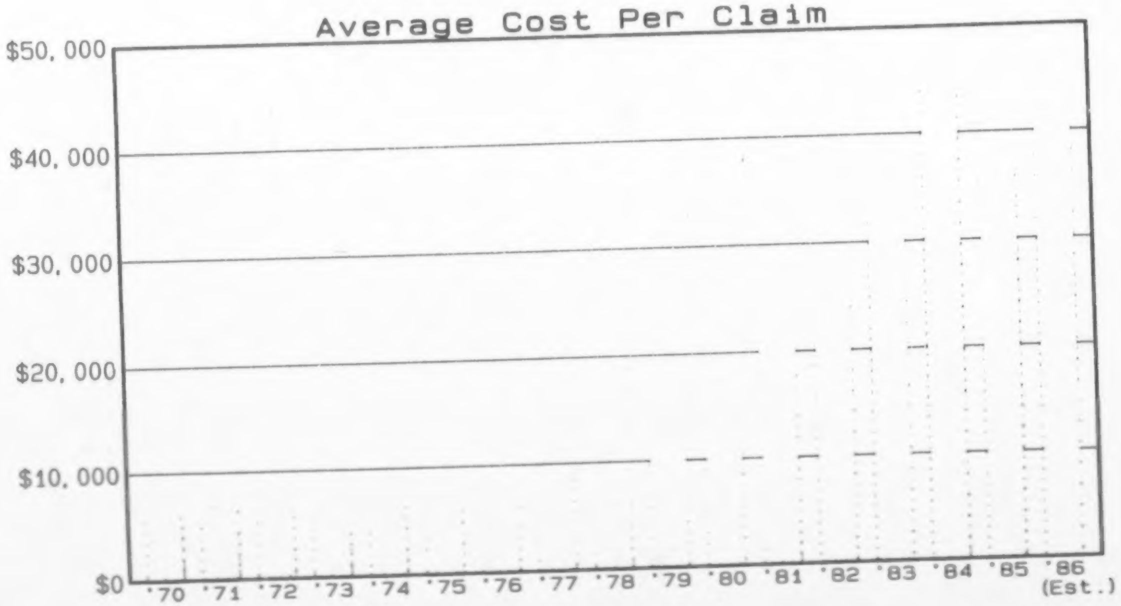
Annual Rate Of Growth = 6.2%

B17607/G.25

CHART 2

CALIFORNIA HOSPITALS

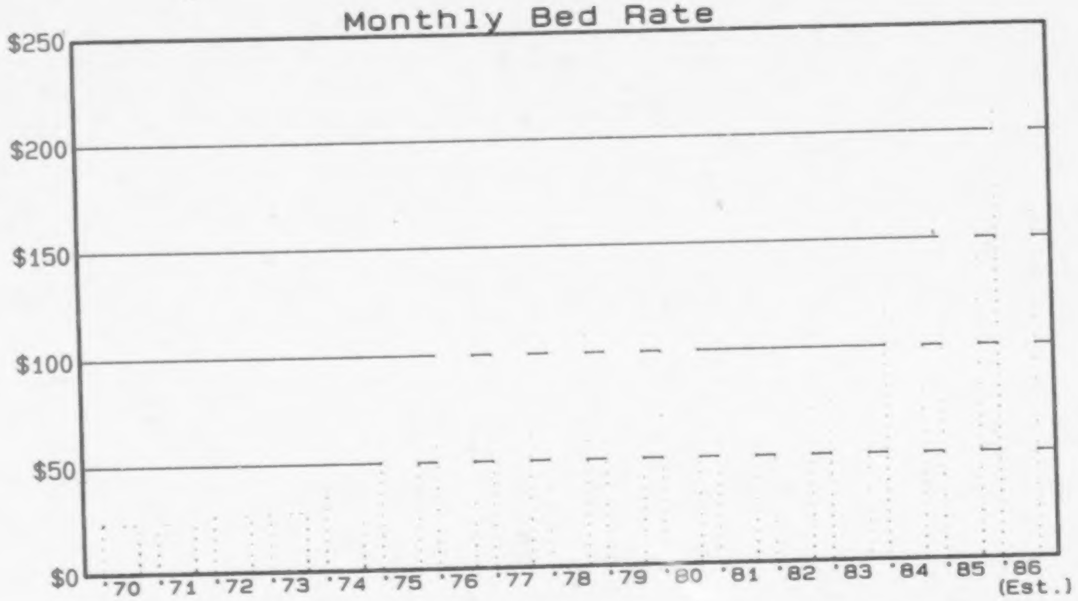
PROFESSIONAL LIABILITY INSURANCE - 1st MM



Annual Rate Of Growth = 15.0%

817606/G.25

CHART 3
CALIFORNIA HOSPITALS
PROFESSIONAL LIABILITY INSURANCE - 1st MM



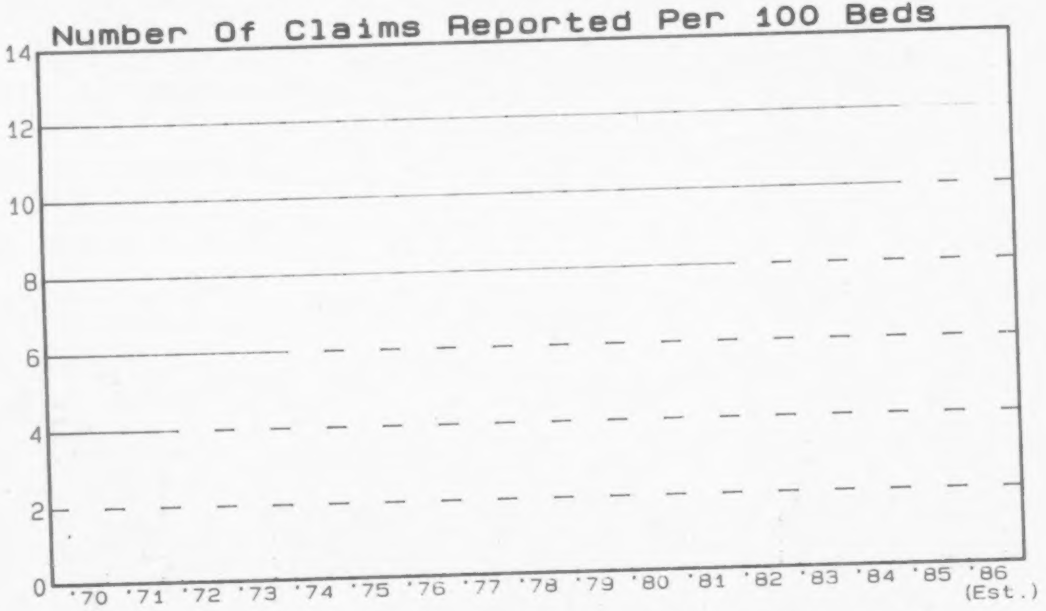
Annual Rate Of Growth = 13.5%

B17603/6.25

CHART 1

CALIFORNIA HOSPITALS

PROFESSIONAL LIABILITY INSURANCE - 1st MM



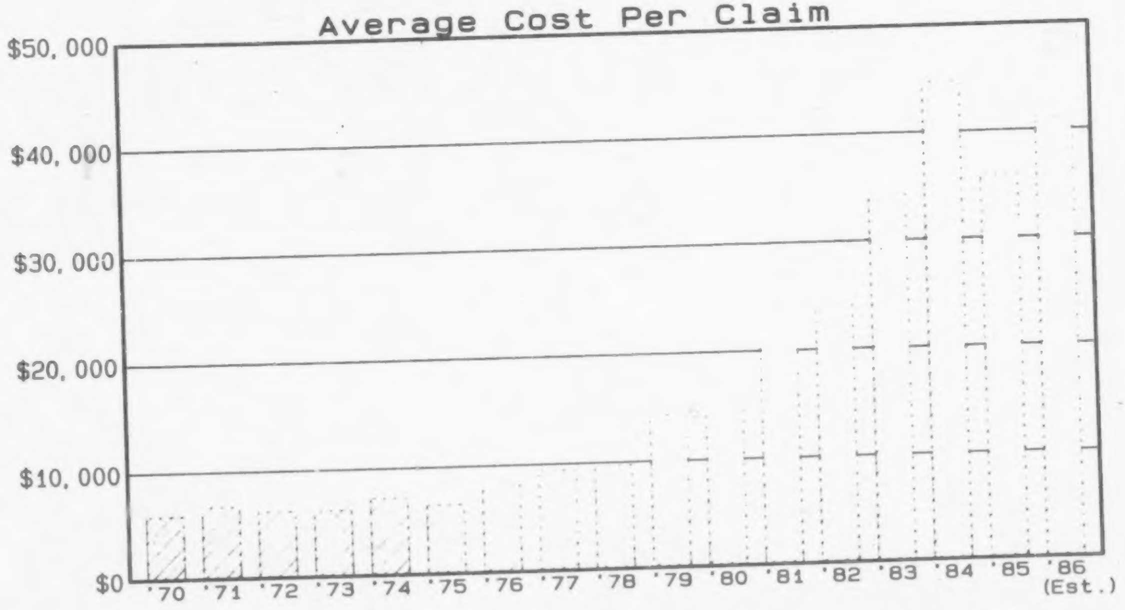
Annual Rate Of Growth = 6.2%

B17607/G.25

CHART 2

CALIFORNIA HOSPITALS

PROFESSIONAL LIABILITY INSURANCE - 1st MM



Average Cost Per Claim

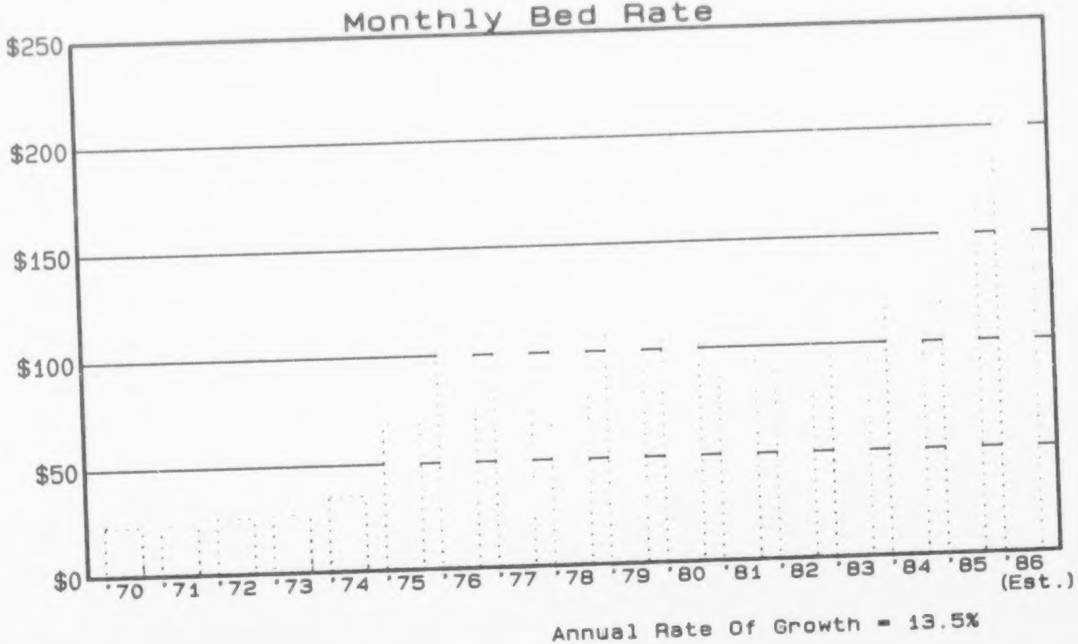
Annual Rate Of Growth = 15.0%

B17606/G.25

CHART 3

CALIFORNIA HOSPITALS

PROFESSIONAL LIABILITY INSURANCE - 1st MM



B17603/G.25

CHART 4

CALIFORNIA HOSPITALS

PROFESSIONAL LIABILITY INSURANCE
$1,000,000 LIMITS

	MONTHLY BED RATE	NUMBER OF CLAIMS REPORTED PER 100 BEDS	AVERAGE COST PER CLAIM
1970	$ 23.42	3.43	$ 5,953
1971	24.06	3.95	6.783
1972	26.91	4.67	6,274
1973	27.90	5.62	6.233
1974	35.77	6.86	7,271
1975	68.51	6.86	6,521
1976	114.30	6.75	8,418
1977	113.07	6.72	9.414
1978	108.25	7.05	9,728
1979	108.94	7.29	14,271
1980	109.89	7.56	14,847
1981	95.75	7.79	20,212
1982	89.86	8.93	24,054
1983	96.33	9.20	34,202
1984	125.60	9.56	44,626
1985	171.82	10.09	35,828
1986	219.10	11.25*	40,815*
Overall Rate of Growth	13.5%	6.2%	15.0%
Combined Rate of Growth		22.2%	

*Estimated.

APPENDIX 2

EXPANSION OF TORT LIABILITY BY CALIFORNIA COURTS

The following is a compilation of California Supreme Court cases decided in the last 20 years which have expanded tort liability in the state and which could be said to be contributing factors to the high cost of insurance.

GENERAL PRINCIPLES

Li v. Yellow Cab Company (1975) 13 Cal.3d 804 [119 Cal.Rptr. 858, 532 P.2d 1226].

In this case, the Supreme Court adopted a system of comparative negligence, replacing the previous system of contributory negligence. Under the new system, contributory negligence is no longer a bar to recovery, but rather, the plaintiff's negligence is compared to the negligence of the defendant with damages being diminished in proportion thereto. By virtue of the decision, the court virtually abolished the doctrines of last clear chance and assumption of risk. The Court held that the two doctrines no longer constitute a bar to recovery but that all negligence of the plaintiff will be factored into a comparative negligence analysis.

American Motorcycle Association v. Superior C[illegible]t (1978) 20 Cal.3d 578 [146 Cal.Rptr. 182, 578 P.2d 899].

The court analyzed the question which was expressly not addressed in Li; that is, how fault is apportioned amongst multiple party defendants. The court held that although the negligence system was altered in Li, it decided to retain the joint and several liability principles existent under the former contributory negligence system. Also, the court altered equitable indemnity principles by abolishing the "active-passive" distinction made by previous courts. Under previous equitable indemnity principals, the tortfeasor who was only "passive" in its negligence was entitled to shift the whole loss to the entity that was "actively" negligent. In American Motorcycle, the court held that "comparative indemnity" would be the rule of law.

The decision paves the way for "deep pocket" liability in that any entity slightly negligent can be held accountable for the entire injury suffered by the plaintiff with no right to shift the loss to the entity who was primarily responsible for the harm.

NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

Dillon v. Legg (1968) 68 Cal.2d 728 [69 Cal.Rptr. 72, 441 P.2d 912].

In this case, the court established a cause of action for a parent who witnesses the negligent infliction of death or personal injury on his or her child. The court allowed the parent to recover for the resulting emotional trauma without requiring, as previous cases, that the parent show that he or she was fearful for his or her own safety.

Krouse v. Graham (1977) 19 Cal.3d 59 [137 Cal.Rptr. 863, 562 P.2d 1022].

In Krouse, the court expanded Dillon to allow recovery to persons who did not actually see the impact which caused the death or personal injury of the victim. Any "sensory observation" of the accident will suffice to give a plaintiff standing to assert a Dillon cause of action.

Ochoa v. Superior Court (1985) 39 Cal.3d 159 [____ Cal.Rptr. ____, ____ P.2d ____].

In this case, the Supreme Court rejected the implicit requirement in Dillon that the accident witnessed by the plaintiff be a "sudden occurrence". The court had previously recognized the existence of such requirement in Justus v. Atchison (1977) 19 Cal.3d 564 (139 Cal.Rptr. 97, 565 P.2d 122]. In Ochoa, the plaintiffs had witnessed the worsening health of their child and the allegedly improper care rendered by the defendant institution. The court held that the plaintiffs could recover for the negligent infliction of emotional distress.

Molien v. Kaiser Foundation Hospitals (1980) 27 Cal.3d 916 [167 Cal.Rptr. 831, 616 P.2d 813].

In a "direct victim" case of emotional distress, the Supreme Court held that a plaintiff no longer needs to prove physical injury in order to make out a claim of emotional distress. The Court distinguished Dillon, stating that language in Dillon which requires a physical manifestation of emotional distress does not apply to a "direct victim" case. In so holding, the Court contravened the holdings of previous Court of Appeals cases.

GOVERNMENTAL LIABILITY

Halfend v. Southern California Rapid Transit District (1970) 2 Cal.3d 1 [84 Cal.Rptr. 173, 465 P.2d 61].

In this case, the Supreme Court held that the "collateral source" rule applies to a governmental entity. The "collateral source" rule is a rule of evidence which disallows the introduction of any evidence relevant to a plaintiff's collateral recovery (e.g., insurance proceeds). The rule ensures that a jury's award will not be reduced by the amount of collateral source payments. The court's holding is directly contrary to language in a previous Supreme Court case (City of Salinas v. Souza, etc. (1967) 66 Cal.2d 217 [57 Cal.rptr. 337]), which stated an exception to the collateral source rule when the defendant is a governmental entity.

Johnson v. State of California (1968) 69 Cal.2d 782 [73 Cal.Rptr. 240, 447 P.2d 352].

In this case, the court construed governmental immunity language contained in the Torts Claim Act. The Act bars plaintiffs from recovering for injuries caused by the "discretionary acts" of public entities. The court held that the Act should not be construed literally and that immunity should apply only to "basic policy decisions" which have a "planning" rather than an "operational" character.

Utilizing this rule, the Court held that the defendant, the State Youth Authority, was liable in damages for a criminal act committed by a parolee subsequent to being paroled by the defendant. The Court rejected the Authority's claim of governmental immunity.

Morris v. County of Marin (1977) 18 Cal.3d 901 [136 Cal.Rptr. 251, 559 P.2d 606].

Using the standard developed in Johnson, the Morris court held that a governmental entity is not always immune from suit when it issues licenses to various third parties. The court held that the Act's immunity applies only to "discretionary licenses and permits." In the case presented, where the county issued a building permit to a contractor, the county was held liable for its negligent acts performed in connection with issuing the license.

Delta Farms Reclamation District v. Superior Court (1983) 33 Cal.3d 699 [190 Cal.Rptr. 494, 660 P.2d 1168].

The court held that the recreational use immunity contained in Civil Code section 846 does not apply to governmental entities. The Code section states that a property-owner owes no duty of care to keep the premises safe for recreational uses such as swimming, hiking, and hunting. The court held that the section did not apply to public entities and that the plaintiffs, parents of a youth who had drowned in a public reservoir, could sue the Reclamation District for wrongful death.

Subsequent to the Delta Farms decision, the legislature passed Government Code section 839.7, which immunized public entities from personal injuries arising from certain recreational activities.

INTERSPOUSAL IMMUNITY

Klein v. Klein (1962) 58 Cal.2d 692 [26 Cal.Rptr. 102, 373 P.2d 70].

The court abolished interspousal immunity in negligence-based torts.

LOSS OF CONSORTIUM

Rodrigues v. Bethlehem Steel Corp. (1974) 12 Cal.3d 382 [115 Cal.Rptr. 765, 525 P.2d 669].

In this case, the Supreme Court overruled previous Supreme Court decisions which had abolished a cause of action for loss of value of consortium due to the injuries of a spouse. In this case, the court allowed a wife to recover damages for loss of consortium due to the personal injuries of her husband.

ABOLITION OF THE GUEST STATUTE

Brown v. Merlo (1973) 8 Cal.3d 855 [106 Cal.Rptr. 388, 506 P.2d 212].

The court held that California Guest Statute, former Vehicle Code section 17158, was unconstitutional in that it violated Equal Protection principles. The former statute had limited the personal injury liability of drivers vis-a-vis nonpaying passengers to injuries caused by the driver's intoxication or willful misconduct. The Brown decision held that drivers are liable to nonpaying passengers where they fail to operate their vehicle as would a reasonably prudent person (negligence).

FURNISHING ALCOHOLIC BEVERAGES TO AN INTOXICATED PERSON

Vesely v. Sager (1971) 5 Cal.3d 153 [95 Cal.Rptr. 623, 486 P.2d 151]; Bernard v. Harris' Club (1976) 16 Cal.3d 313 [128 Cal.Rptr. 215, 546 P.2d 719]; Coulter v. Superior Court (1978) 21 Cal.3d 144 [145 Cal.Rptr. 534, 597 P.2d 669].

In these three cases, the court held that a person who sells or gives an alcoholic beverage to an obviously intoxicated person is liable for injuries caused by that person's negligent driving. For example, in Vesely, the court held a bar owner liable in damages when its bartender sold drinks to an obviously intoxicated patron. In Bernard, the court found liability where a Nevada casino had furnished drinks to a driver who was obviously intoxicated and whose car hit a motorcyclist. Finally, in Coulter, a social host was held liable for furnishing drinks to a driver who ran into a highway abutment. The court held that the passenger of the car had a personal injury claim against the social host.

As a result of these cases, the legislature amended both the Civil Code and the Business and Professions Code so that no person who sells or furnishes alcohol to another person will be civilly liable for injuries caused by the intoxication of the consumer of the beverage. B&P Code section 25602; Civ. Code section 1714. The express legislative purpose of the amendments was to abrogate the holdings of Coulter, Bernard, and Vesely.

WRONGFUL TERMINATION

Tameny v. Atlantic Richfield Company (1980) 27 Cal.3d 167 [164 Cal.Rptr. 839, 610 P.2d 1330].

In this case, the court created a new tort of wrongful discharge. The court held that a discharged employee may pursue a tort remedy where the discharge constitutes a violation of the fundamental principals of public policy. In examples given by the court, an employee's discharge constitutes a violation of public policy where the employee is terminated because of: the employee's refusal to commit perjury, for union membership or activity, for serving on a jury, for filing workmen's compensation claims, or for reporting violations of consumer protection laws.

PROFESSIONAL LIABILITY

Smith v. Lewis (1975) 13 Cal.3d 349 [118 Cal.Rptr. 621, 530 P.2d 589].

The Supreme Court expanded the duties of an attorney to include the duty to discover those additional rules of law, although not commonly known by well-informed attorneys, which may be readily found by standard research techniques. The case broke with prior precedent which established that an attorney should not be liable for errors in questions of law on which reasonable doubt may be entertained by well-informed attorneys.

Tarasoff v. Regents of the University of California (1976) 17 Cal.3d 425 [131 Cal.Rptr. 14, 551 P.2d 334].

The court extended the duties of a psychotherapist to protect third parties from the violence of his or her patient. The court held that a psychotherapist has the duty to use reasonable care possessed by members of that profession in predicting whether a patient poses a serious danger of violence to another. In addition, a psychotherapist must exercise reasonable care to protect the foreseeable victim from that danger.

Cobbs v. Grant (1972) 8 Cal.3d 229 [104 Cal.Rptr. 505, 502 P.281].

This case expands the liability of a physician, identifying a separate theory of negligent failure to sufficiently disclose the risks inherent in a course of treatment or operation. Previously, the only cause of action which would pertain to inadequate disclosure was a battery cause of action.

Truman v. Thomas (1980) 27 Cal.3d 285 [165 Cal.Rptr. 308, 611 P.2d 902].

The Truman court expanded Cobbs and held that a physician was liable for not disclosing the risks involved in not undergoing a prescribed test or procedure. The court held that a physician was liable for such nondisclosure where the "reasonable prudent person in the patient's position would not have refused the test if the patient had been adequately informed of all the significant perils."

Turpin v. Sortini (1982) 31 Cal.3d 220 [182 Cal.Rptr. 337, 643 P.2d 954].

The court held that a child may bring a "wrongful life" action against the health care provider who negligently fails to advise the child's parents of the possibility of hereditary infliction. Although not allowing an award of general damages, the court authorized an award of "extraordinary expenses" calculated over the lifetime of the child (e.g., special education, special training). In dicta, the court also recognized a cause of action for the parents of the child: a "wrongful birth" action.

LIABILITIES OF A LENDER

Connor v. Great Western Savings and Loan Association (1968) 69 Cal.2d 850 [73 Cal.Rptr. 369, 447 P.2d 609].

The court held a lender liable for the substandard construction of a housing development financed by the lender. The court found that the lender was in a position to require the borrower-contractor to take due care not to injure the occupants of the development.

This decision was subsequently undermined by the legislature in Civil Code section 3434. The Code Section exculpates a lender from liability for construction flaws except in limited situations outlined in the statute.

PROPERTY OWNERS' LIABILITY

Rowland v. Christian (1968) 69 Cal.2d 108 [70 Cal.Rptr. 97, 443 P.2d 561].

In Rowland, the court abrogated the common law rules regarding a property owner's liability for injuries occurring on the property. Under the common law rule, a property owner's liability depended upon the status of the injuried party vis-a-vis the owner, i.e., whether a third party was a trespasser, licensee, or invitee. Under the common law, there was a reduced standard of care flowing from the property owner to licensees and trespassers. The court abrogated the former distinctions, annunciating the new rule that a property owner has the duty of reasonable care as to all foreseeable victims of the property owner's negligence, regardless of the victim's status.

Isaacs v. Huntington Memorial Hospital (1985) 38 Cal.3d 112 [211 Cal.Rptr. 356, 695 P.2d 653].

In this case, the court rejected a solid line of authority regarding a landowner's negligence liability for criminal acts of third persons. In prior cases, courts of appeals have held that in the absence of prior similar incidents, an owner is not liable for the criminal actions of third parties. The Supreme Court in Isaacs held that a property owner's liability for criminal acts is to be determined on a case-by-case basis, using "foreseeability" principals. Thus, a landowner can now be held responsible for a third-party's criminal acts even where there is no evidence of prior similar acts.

Beck v. IRM Corporation (1985) 38 Cal.3d 454 [213 Cal.Rptr. 213, 698 P.2d 116].

The court held that a landlord may be strictly liable for latent defects existing in the rented premises at the time the tenant rented the premises. This is the first California case which extended products strict-liability concepts to a lessor of property.

Sprecher v. Adamson Companies (1981) 30 Cal.3d 358 [178 Cal.Rptr. 783, 636 P.2d 1121].

The court overturned a common law rule which immunized the property owner from liability to persons outside the premises for harm caused by the natural conditions on the premises.

PRODUCTS LIABILITY

Cronin v. J.V.E. Olson Corp. (1972) 8 Cal.3d 121 [104 Cal.Rptr. 433, 501 P.2d 1153].

In this design defect case, the court altered the test for proving the existence of a design defect. Previous California cases had used the Restatement of Torts test in outlining the elements of a design defect. The test required a showing that the product was "unreasonably dangerous and unsafe for its intended use". The court in Cronin rejected the Restatement formulation, holding that a plaintiff must only prove that the product contained a defect which proximately caused the plaintiff's injury.

Sindell v. Abbott Laboratories (1980) 26 Cal.3d 588 [163 Cal.Rptr. 132, 607 P.2d 924].

The court in Sindell established the "market share" test of products liability. The plaintiff in Sindell could not identify the particular manufacturer of the defective drug (DES) which caused the plaintiff's injuries. The court held that the plaintiff could recover from the group of manufacturers according to their proportional share of the market, if the plaintiff could prove: (1) plaintiff's injuries were caused by a drug, individual batches or doses of which were produced from an identical formula by a number of manufacturers; (2) the injuries were caused by a defect common to all batches of the product; (3) plaintiff cannot identify the producer of the particular batch that caused the injuries; (4) plaintiff sues defendants who marketed a "substantial" share of the batches from which the injurious dose must have come.

Although the issue is undecided, it is possible that each defendant remains jointly and severally liable for all of the plaintiff's damages by analogy to comparative indemnity principles established in American Motorcycle Association.

Ault v. International Harvester Co. (1974) 13 Cal.3d 113 [117 Cal.Rptr. 812, 528 P.2d 1148].

The court held that Evidence Code section 1151, which excludes from trial evidence of subsequent remedial conduct, is not applicable to products liability cases founded on strict liability. As such, subsequent repairs of a product can be used as evidence against a retailer or manufacturer.

Luque v. McLean (1972) 8 Cal.3d 136 [104 Cal.Rptr. 443, 501 P.2d 1163].

The court held that a manufacturer or retailer may be liable for "patent defects" in a product, i.e., where the consumer was aware or should have been aware of the defect in question. This decision runs contrary to previous court of appeals cases which held that a plaintiff could not recover for a patent defect in a product.

Elmore v. American Motors Corp. (1969) 70 Cal.2d 578 [75 Cal.Rptr. 652, 451 P.2d 84].

In Elmore, the court expanded strict liability concepts in the product realm to encompass actions by bystanders harmed by defective products. The court rejected the argument that only those in privity of contract with the manufacturer may recover for products liability.

BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING

In the Insurance Context

Crisci v. Security Insurance Co. (1967) 66 Cal.2d 425 [58 Cal.Rptr. 13, 426 P.2d 173].

The Crisci court upheld a determination made by the Court in Comunale that the insurer can be liable when it fails to act reasonably and in good faith settle claims against the insured. Communale v. Traders and General Ins. Co. (1958) 50 Cal.2d 654 [328 P.2d 198]. Crisci, however, expanded an insurer's liability by allowing recovery for economic loss and emotional distress. Communale had only authorized a recovery for the amount in which a third-party's recovery exceeded an insured's policy limits.

Silbert v. California Life Ins. Co. (1977) 11 Cal.3d 452 [113 Cal.Rptr. 711, 521 P.2d 1103].

This case established that an insured may recover punitive damages from an insurer for the breach of the duty of good faith and fair dealing.

Gruenberg v. Aetna Ins. Co. (1973) 9 Cal.3d 566 [108 Cal.Rptr. 480, 510 P.2d 1032].

The court held that a plaintiff need not prove "severe" emotional distress in order to recover damages for emotional distress in a bad faith case. Although the plaintiff must prove severe distress in an action for intentional infliction of emotional distress, the focus in a bad faith action is on a "substantial invasion of property interests."

Egan v. Mutual of Omaha Ins. Co. (1979) 24 Cal.3d 809 [157 Cal.Rptr. 482, 598 P.2d 452].

In Egan, the court held that a jury may award as damages future policy benefits that the policyholder would have been entitled to receive had the contract been honored by the insurer.

Royal Globe Ins. Co. v. Superior Court (1979) 23 Cal.3d 880 [153 Cal.Rptr. 842, 592 P.2d 329].

In this case, the Supreme Court sanctioned a statutory remedy by third parties against insurance carriers that engage in unreasonable, unnecessary and wrongful delays in compensating third-party claimants. The court held that violations of Insurance Code section 790.03(h) gave rise to a civil action for damages in favor of third party claimants.

The case is significant because third party claimants had been previously foreclosed from pursuing common law bad faith actions without an assignment of rights from the insured (Murphy v. Allstate Ins. Co. (1976) 17 Cal.3d 937 [132 Cal.Rptr. 424].) The Royal Globe court allowed a plaintiff to collect damages for economic loss, emotional distress, and punitive damages under the statutory cause of action.

In the Non-insurance Context

Seaman's Direct Buying Service, Inc. v. Standard Oil Co. of California (1984) 36 Cal.3d 752 [206 Cal.Rptr. 354, 686 P.2d 1158].

In this case, the Supreme Court created a new tort of commercial bad faith. The court identified two bases on which a plaintiff may use the new cause of action to recover. One basis, that relied on by the Seaman's court, is where a defendant sought to shield itself from liability by denying in bad faith and without probable cause the existence of a binding contract. The other basis of recovery is where a plaintiff can show that a "special relationship" exists between the contracting parties analogous to that between an insured and an insurer. A "special relationship" is characterized by the elements of public interest, adhesion, and fiduciary responsibility. Subsequent court of appeals cases have relied on the "special relationship" language in Seaman's to allow a tort recovery for breach of contract. See, e.g., Wallis v. Superior Court (1984) 160 Cal.App.3d 1109 [207 Cal.Rptr. 123]; Commercial Cotton Co. v. United California Bank (1985) 163 Cal.App.3d 511 [209 Cal.Rptr. 551].

Tameny v. Atlantic Richfield Company, supra.

In this wrongful termination case, the court did not reach the issue of whether the plaintiff stated a cause of action for breach of the covenant of good faith and fair dealing. It, however, cited with approval cases in other jurisdictions which have allowed such a cause of action.

Prepared by the law firm of

HASSARD, BONNINGTON, ROGERS & HUBER
San Francisco, California

Mr. Ryan. I notice that Mr. Wilton is accompanied by general counsel, Mr. Mannen, from the association.

Mr. Wilton, please.

Mr. Wilton. Thank you, Mr. Ryan.

I am Frank P. Wilton, President of Ethox Corp., a small company based in Buffalo, NY, that manufactures disposable medical and diagnostic products.

As chairman of the board of the Health Industry Manufacturers Association, HIMA, I am pleased to testify today on S.1804, the proposed Federal Incentives for State Health Care Professional Liability Reform Act.

HIMA is a national trade organization representing over 300 manufacturers of medical device and diagnostic products. HIMA companies make products that span the spectrum of medical technology, from tongue depressors to sophisticated lifesaving innovations. The large majority of HIMA members are smaller companies like my own. In fact, two-thirds of our 300 members do less than $20 million in volume and, as such, are particularly sensitive to the effects of Government policies on their ability to supply medical innovations for America's patients.

HIMA applauds this committee for its attention to the liability insurance concerns of health care professionals and institutions and to the effects liability insurance problems have on patient access to quality care.

We are here today to suggest that patient access to quality care could be further protected by applying the tort reforms of S.1804 to the manufacturing medical technology sector of the health care delivery system.

We have submitted a formal proposal and text to the Committee, and therefore I would like to just summarize some of the key points in keeping with time pressures.

Mr. Ryan. We appreciate that, Mr. Wilton.

Mr. Wilton. Specifically, we would like to leave the Committee with three points. Like health care professionals and institutions, medical technology companies face serious problems of liability insurance availability and affordability.

One-third of our members lost their product liability insurance coverage in 1985, and except for a captive insurance company founded by our industry, many of them would be going bare, with no protection whatsoever.

One of our members in Ohio had a 4,000-percent increase in their premiums, which added 5 percent to product cost, and another small Midwestern medical device company had to increase prices 10 percent just to cover the cost of product liability insurance.

The company of which I am president in 1986 had its coverage reduced by 80 percent, and the cost of it doubled, and, therefore, we had almost a tenfold increase in our product liability insurance, and we have never had a product liability claim in the 20 years of our existence.

Second, the tort reforms in S. 1804 should apply to medical technology companies as well as to professionals and institutions. Reforming only two-thirds of the system could unintentionally encourage plaintiffs to seek larger awards from the remaining unprotected part of the system, the medical technology area.

Secretary Bowen in his testimony mentioned that people expect miraculous results from medicine today, and we in the medical technology area feel that we have played an important role in those expectations, and we also feel that we need to be protected, as suggested here.

Third, making medical technology developers a larger target for plaintiffs could exacerbate defensive innovation, which limits the availability of the tools professionals and institutions need to deliver quality care to patients.

In the last 2 months, our company has passed up two opportunities to work on and develop new products because we felt that there were excessive product liability exposures, and on that basis we decided not to proceed.

We also mention in our written testimony that one of the major factors in the infant ventilator business has withdrawn from that market because the exposures did not make it commercially feasible.

Finally, HIMA would like to applaud the Committee for its attention to the liability insurance concerns of health care professionals and institutions. We think, however, it makes good sense and good policy to craft a comprehensive response to health care liability insurance problems by applying S. 1804 reforms to the manufacturing medical technology sector of the health care delivery system. In fact, we suggest that this would be the third leg on the stool that would make this a comprehensive program. This would help S.1804 to achieve its goal of assuring access to patients of quality care.

That completes my remarks.

[Prepared statement of Mr. Wilton follows:]

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Statement

By

Frank P. Wilton
President, Ethox Corp.

Representing The

Health Industry Manufacturers Association

Before The

Committee on Labor and Human Resources

United States Senate

September 11, 1986

an association representing the medical device and diagnostic product industry

Mr. Chairman, I am Frank P. Wilton, President of Ethox Corp., a small company based in Buffalo, New York, that manufacturers disposable medical and diagnostic products. As Chairman of the Board of the Health Industry Manufacturers Association (HIMA), I am pleased to testify today on S. 1804, the proposed "Federal Incentives for State Health Care Professional Liability Reform Act."

Introduction

HIMA is a national trade association representing over 300 manufacturers of medical devices and diagnostic products. HIMA companies make products that span the spectrum of medical technology, from tongue depressors to sophisticated life-saving innovations. The large majority of HIMA members are smaller companies like my own and, as such, are particularly sensitive to the effects of government policies on their ability to supply medical innovations for America's patients.

HIMA applauds this Committee for its attention to the liability insurance concerns of health care professionals and institutions and to the effects liability insurance problems have on patient access to quality care. We are here today to suggest that patient access to quality care could be further protected by applying the tort reforms of S. 1804 to the manufacturing sector of the health care delivery system.

We hasten to add that our goal is not to change the apportionment of ultimate tort responsibility or to "solve" one health care segment's liability insurance problems at the expense of others. Instead, we seek a "health care liability" approach that recognizes health care delivery as the unified whole it truly is.

More specifically, we would like to leave with the Committee three points:

- Like health care professionals and institutions, medical technology companies face serious problems of liability insurance availability and affordability.

- The tort reforms in S. 1804 should apply to technology companies as well as to professionals and institutions. Reforming only two-thirds of the system could unintentionally encourage plaintiffs to seek larger awards from the remaining unprotected part of the system -- the technology developer.

- Making technology developers a larger target for plaintiffs could exacerbate "defensive innovation," which limits the availability of the tools professionals and institutions need to deliver quality care to patients.

Liability Insurance Problems in Health Care

Health care risks are different than those in sports or gardening. This is because health care deals with the delicate balance between a patient's condition (which by definition poses some risk to his well-being) and the available technologies and expertise to treat that condition.

This Committee has heard testimony about the liability insurance problems facing professionals and institutions. We want the Committee to know that these same kinds of problems face technology developers.

More specifically, our industry has experienced serious problems of insurance availability and affordability. One survey shows that in 1985, one in five technology companies had their product liability insurance cancelled or not renewed. Those companies that were able to purchase insurance often paid premium increases of 500 to 1,000 percent.

HIMA believes that the Committee should address the liability insurance problems of not just professionals and institutions, but of technology companies as well.

Applying Tort Reforms to All Three Parts of the System

We think it makes sense to apply S. 1804's tort reforms to all three parts of the health care delivery system. In fact, applying them to only two-thirds of the system could have unintended consequences for technology developers.

For example, S. 1804 would encourage states to cap awards for non-economic losses against professionals and institutions. While well intended, this provision could encourage plaintiffs to seek larger awards from technology companies, the one part of the delivery system unprotected by the cap and thus legally susceptible to higher awards.

This artificial shift in liability exposure to manufacturers could exacerbate an already serious threat to technological innovation.

"Defensive Innovation"

If the liability insurance problem is causing "defensive medicine" to be practiced by providers, there are signs it is causing "defensive innovation" to be practiced by technology developers.

Considerable attention has properly focused on the effects of professional liability insurance availability and affordability on patient access to quality care. The decision by some physicians not to deliver babies is perhaps the best known example.

But access is no less impeded if a physician, having delivered the baby, cannot obtain the technology needed to help the baby survive. One manufacturer, for example, has refrained from producing infant ventilators because of liability concerns. In the last decade, this technology has boosted the survival rate for premature babies with respiratory distress syndrome from 30 percent to over 90 percent. But the risk of multimillion dollars suits by families of those 10 percent who can't be saved is so great as to deter production of this important tool for the physician.

Risk aversion by medical technology manufacturers results in companies abandoning health-enhancing products rather than facing potential liability. This raises the prospect that "high risk" product lines, many of which are life-saving or life-sustaining, will not be available to patients who need them. Technology companies simply have little incentive to surmount already formidable FDA and Medicare hurdles when the light at the end of the tunnel is a tort system gone astray.

Conclusion

HIMA lauds the Committee for its attention to the liability insurance concerns of health care professionals and institutions. We think, however, that it makes good sense and good policy to craft a comprehensive response to the health care liability insurance problem by applying S. 1804's tort reforms to the manufacturing sector of the health care delivery system. This would help S. 1804 better achieve its goal of assuring the access of patients to quality care.

Mr. **Ryan**. Thank you, Mr. Wilton.

I would like to ask both you gentlemen, do you favor Federal regulation of insurance?

Mr. **Forbes**. Not at this time, from my own personal experience, because we have tried to address it at the State level, and basically, California has instituted a number of measures, as I testified to, that would be mandated under your proposed legislation.

In fact, most all have been already enacted in California, and I think this should be allowed to determine after a period of time how effective it has been.

Now, if the Federal Government has a rôle, I think it probably is in the area in which I believe Senator Grassley mentioned, certainly the antitrust laws, vis-a-vis peer review and disciplinary functions. And I would strongly urge that consideration be given in that area, because I do know that physicians are very much concerned about the threat of antitrust litigation for peer review activities. They are protected in California, but I would also urge that they be protected at the Federal level, and I would also urge that not only physicians be protected, but since they are by and large functioning as members of a hospital medical staff, the hospitals could also be included within the protection, or it will wind up bearing the brunt of the antitrust allegation and violation.

Mr. **Ryan**. Mr. Wilton?

Mr. **Wilton**. I would say on behalf of HIMA that S. 1804 represents the kind of Federal activity that we would welcome. We think it would be more complete if it included the institutions, the professionals, and the medical technology providers. I think we believe that federal leadership with this type of legislation will help. Ultimately, I think we believe that the States are going to have to get actively involved in it and change their procedures, and we think this type of law will encourage them to do so, and on that basis we recommend it and are enthusiastic about it.

Mr. **Ryan**. Mr. Wilton, I believe you testified that your company has passed up opportunities for new product entry into the medical device community. Can you tell us something more about that, as well as whether other medical device companies are going through that same kind of consideration, what the impact of this crisis has been on them?

Mr. **Wilton**. I would be happy to. The two examples that I mentioned in general were in the field of enteric feeding; a very active part of medical care today is feeding patients nasogastrically into their enteric system in order to give them the necessary nutrients to fight off infection. Our company is a manufacturer of nasogastric tubes which are placed through the nose, into the stomach or the small bowel.

A major problem is having patients pull these tubes out of their systems, in most cases irrationally. They are unhappy with the feeling of them, and even though it is deleterious to their health, they will pull them out.

A physician developed a very innovative technique for anchoring the tube to the nasal passages. Our feeling was that it was good technology. However, because a lot of these tubes are pulled out by irrational patients, we felt that some of them would seriously injure the nasal part of their face, and that ultimately would lead to suits, and that was one of the reasons why we advised the physician that we would not proceed with the development of the product.

The second item was in the area of what is known as the "tummy bubble", which is a new technology for weight reduction, which is very important to people who are obese. We were approached by an inventor to come out with a second-generation tummy bubble, and again, the fact that the product liability would be such a problem caused us to back away from that opportunity.

Speaking on behalf of our 300 members, I know that many of them are withdrawing products from the market or not going ahead with the development programs because of the product liability exposure issue.

Mr. RYAN. Is that just because of product liability and that field of law, or does it also relate to the availability and reasonableness of cost of insurance?

Mr. WILTON. In our case, as I mentioned, our product liability insurance went up 10 times this last year for the exposure that we had. Our insurance company actually made a proposal to us that if we would drop a product line, if we would withdraw from a market, that they would significantly reduce our premium. I decided not to do that in 1986. I can assure you that I am reviewing that, and we may well drop that product line in 1987 for a substantial reduction in our over-six-figure premium that we are paying for product liability right now.

So we may actually move out of a market because of product liability cost considerations.

Mr. RYAN. Do you think that is in the best interests of the patients who benefit from medical devices?

Mr. WILTON. I certainly do not. I think that we have the greatest health care in the world, and I think medical technology and the professionals and the institutions make this happen. It certainly will reduce access to quality medical care if people withdraw good products from the marketplace.

Mr. RYAN. Thank you, Mr. Wilton, Mr. Forbes, Mr. Mannen.

Our fifth and final panel is made up of Ms. Paula Gold, Secretary of the Commonwealth of Massachusetts Department of Consumer Affairs and Business Regulation and Mr. Gerald Wester, deputy commissioner of the Department of Insurance for the State of Florida.

We would like to welcome you to this hearing and ask that you proceed.

STATEMENTS OF PAULA W. GOLD, SECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION FOR THE COMMONWEALTH OF MASSACHUSETTS, BOSTON, MA.; AND GERALD WESTER, DEPUTY COMMISSIONER, DEPARTMENT OF INSURANCE, TALLAHASSEE, FL

Ms. GOLD. Thank you. Good afternoon.

My name is Paula Gold, and I am secretary of consumer affairs and business regulation for the Commonwealth of Massachusetts. I have cabinet-level responsibility in Massachusetts for 9 State agencies ranging from banking and insurance to the racing commission, as well as 28 licensing boards including the board of registration in medicine. I am also the chairperson of Governor Dukakis' Task Force on Liability Issues, which was formed last March to address a broad range of liability and insurance concerns.

I have been very much involved with the issue of medical malpractice in Massachusetts for over 2 years now. About 2½ years ago, physicians approached us, and they were concerned about the prospect of rising medical malpractice premiums.

To briefly summarize my testimony, Massachusetts has somewhat of a unique situation in terms of medical malpractice insurance. In 1975, to address or first crisis, a crisis of availability, we established a JUA, a Joint Underwriting Association, which is basically a nonprofit entity. There really is not a private market in terms of medical malpractice in Massachusetts.

We do also have restrictions on physician income that do not exist in other States. Therefore, our solution to the current problems very much have to be viewed in light of those factors.

Governor Dukakis filed a comprehensive medical malpractice package some time ago; it passed the legislature in July of this year. There were three major areas that that legislation addressed: First, better policing of physicians; second, improvements in our insurance system, and third, improvements in our system of compensating wrongfully injured victims of medical malpractice.

In terms of the tort reforms that were contained in that package, there is a partial repeal of the collateral source rule, a $500,000 cap on noneconomic damages, and a graduated scale in terms of attorneys' fees.

There also are a great many provisions dealing with beefing up our board of medicine in terms of reporting requirements, in terms of their authorization to promulgate minimum standards for care, quality control and risk management. And we are now involved in the process of implementing the medical malpractice legislation.

We believe that by addressing these three areas, we have stabilized the medical malpractice situation in Massachusetts. I think there is no question that in a few years we will have to relook at it. But we will be in a much better position at that time as a result of much of what is contained in this legislation.

The legislation also contains provisions for increasing physician income through increases in Blue Shield, Medicaid payments, workmen's compensation, et cetera, which may be very unique to Massachusetts because we have unique restraints on income in Massachusetts.

Based on our experience with medical malpractice and other liability areas, I would urge this committee to evaluate carefully the desirability of Federal intervention in this area. In particular, many aspects of medical malpractice appear to be more suited to State-by-State reforms rather than Federal mandates.

However, we would encourage Congress to explore ways that the Federal Government can improve the quality assurance aspects of State medicine boards. Federal action could assist in developing nationwide sharing of physician disciplinary and performance data to reduce the problem of incompetent physicians moving from State to State to remain in practice. The Federal Government through grants and startup programs could improve the staffing of State boards and perhaps provide training comparable to the FDIC's training of State bank examiners.

The Federal Government as the largest purchaser of health care could play an instrumental role in developing risk management and quality assurance programs.

I would urge you to explore these areas as potentially far more effective Federal involvement than imposing nationwide medical malpractice liability standards.

In contrast, there are other areas of the liability crisis which may be more suitable for direct Federal resolution. Product liability in particular would lend itself to a uniform national approach. Manufacturers now face 50 different standards of liability, and it is unclear that legal changes enacted in one State will have a material impact on insurance availability or cost for interstate industries.

Congress should also examine the question of Federal versus State regulation of the insurance industry, or at least some increased role, or some role, for the Federal Government in regard to regulation of the insurance industry. The partial exemption of insurers from the antitrust laws, for example, is a purely Federal question that should be scrutinized. Direct Federal regulation is another. With increasingly complex insurance and financial markets, and a truly national or international insurance industry, individual State insurance departments may lack the resources or ability to effectively regulate certain insurance activities.

Individual States may also lack the leverage to be able to impose regulatory limits on insurers in the face of threats to withdraw entirely from the State. Moreover, the international reinsurance market is not subject to effective regulation by any State nor is it regulated federally.

The Federal Government has had a negligible role in insurance regulation up to now. That situation should be at least looked at in view of the present nationwide disruption of the insurance markets.

Finally, I would also urge you to be skeptical of across-the-board solutions. Reforms must be tailored to the particular problem or industry affected. What may work for medical malpractice may not make any difference at all to a municipality or a daycare center or a manufacturer. And in particular those activities which are wholly within a State's border are subject to the State having an impact onit. It is when the activities are not wholly within one States borders that the Federal Government's role becomes much more necessary.

Moreover, the public policy behind reforms in one area may be dramatically different if those reforms are suggested in another context.

I commend the committee's concern with the medical malpractice issue and other issues of legal liability, and I urge that you carefully tailor any resulting Federal legislation to areas calling for Federal rather than State solutions and structure any Federal remedies to specific industries or areas of liability in which those remedies will have meaningful, demonstratable results.

Thank you.

[The prepared statement of Ms. Gold follows:]

TESTIMONY OF PAULA W. GOLD
SECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION
FOR THE COMMONWEALTH OF MASSACHUSETTS
BEFORE THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

September 11, 1986

GOOD MORNING. MY NAME IS PAULA GOLD. I AM THE SECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION FOR THE COMMONWEALTH OF MASSACHUSETTS. IN OUR MASSACHUSETTS STATE GOVERNMENT, I HAVE CABINET LEVEL RESPONSIBILITY FOR NINE MAJOR AGENCIES RANGING FROM OUR BANKING AND INSURANCE DIVISIONS TO THE RACING COMMISSION, AS WELL AS 28 STATE LICENSING BOARDS, INCLUDING THE BOARD OF REGISTRATION IN MEDICINE. I AM ALSO THE CHAIRMAN OF GOVERNOR DUKAKIS' TASK FORCE ON LIABILITY ISSUES, FORMED LAST MARCH TO ADDRESS A BROAD RANGE OF LIABILITY AND INSURANCE CONCERNS.

I APPRECIATE THE OPPORTUNITY TO TESTIFY THIS MORNING ON MASSACHUSETTS' APPROACH TO RESOLVING THE MEDICAL MALPRACTICE CRISIS, AS WELL AS ON ITS IMPLICATIONS FOR RESOLVING OTHER LIABILITY ISSUES.

MORE THAN TWO YEARS AGO, WE BEGAN HEARING OF DEEPENING CONCERN AMONG OUR PHYSICIANS THAT A MEDICAL MALPRACTICE INSURANCE CRISIS WAS APPROACHING. GOVERNOR DUKAKIS NAMED AN ADVISORY GROUP TO HELP US TO DEVELOP LEGISLATIVE PROPOSALS, AND IN OCTOBER 1985, THE GOVERNOR FILED A COMPREHENSIVE MEDICAL MALPRACTICE REFORM BILL. THAT BILL FORMED THE BASIS OF MEDICAL MALPRACTICE LEGISLATION ENACTED THIS YEAR, AND WE ARE NOW IN THE PROCESS OF IMPLEMENTING THOSE REFORM MEASURES.

IN LOOKING AT THE AREA OF MEDICAL MALPRACTICE, IT BECAME CLEAR TO US THAT THREE MAJOR CONCERNS WOULD HAVE TO BE ADDRESSED IN ANY REFORM LEGISLATION: BETTER POLICING OF PHYSICIANS, IMPROVEMENTS TO [illegible] INSURANCE SYSTEM, AND IMPROVEMENTS TO OUR SYSTEM OF COMPENSATING WRONGFULLY INJURED VICTIMS OF MEDICAL MALPRACTICE. ADDRESSING ONLY ONE OF THOSE AREAS WOULD NOT RESOLVE THE PROBLEMS WE WERE SEEING, BUT BY ADDRESSING ALL THREE AREAS, WE WOULD HAVE SOME HOPE OF STABILIZING AND IMPROVING THE SITUATION.

IN THE AREA OF BETTER POLICING OF THE MEDICAL PROFESSION, WE FOUND THAT THE EXISTING SYSTEM IN MASSACHUSETTS WAS INADEQUATE. INSTANCES OF MEDICAL MALPRACTICE WERE NOT ONLY NEVER REPORTED TO THE BOARD OF REGISTRATION IN MEDICINE, BUT THE MALPRACTICE LEGAL SYSTEM ACTUALLY ENCOURAGED NONREPORTING THROUGH TRYING TO KEEP MALPRACTICE SETTLEMENTS "SILENT". PHYSICIANS WHO HAD BEEN FOUND LIABLE FOR MULTIPLE CASES OF MALPRACTICE IN SEVERAL INSTANCES HAD NEVER BEEN REPORTED TO THE BOARD OF REGISTRATION FOR ANY OF THE CLAIMS. THIS DEPRIVED OUR DISCIPLINARY AGENCY OF CRUCIAL INFORMATION NECESSARY TO HELP INVESTIGATE AND PREVENT MEDICAL MALPRACTICE.

OUR MEDICAL MALPRACTICE REFORM BILL INCLUDES A BROAD SPECTRUM OF MANDATORY REPORTING PROVISIONS, AS WELL AS INCREASED POWERS AND RESOURCES FOR THE MEDICINE BOARD. PART OF ANY ATTEMPT AT MEDICAL MALPRACTICE REFORM MUST INCLUDE IMPROVED EFFORTS TO WEED OUT THE SMALL NUMBER OF PHYSICIANS WHO SHOULD NOT BE PRACTICING, OR WHO SHOULD CHANGE THEIR METHOD OF PRACTICE. HOWEVER, ELIMINATING THE "BAD" PHYSICIANS BY ITSELF WILL NOT SOLVE THE MEDICAL MALPRACTICE CRISIS.

THE SECOND MAJOR AREA OF OUR MALPRACTICE LEGISLATION CONCERNED THE INSURANCE SYSTEM. MASSACHUSETTS' SITUATION IN THIS REGARD WAS UNLIKE EVERY OTHER STATE. IN ESSENCE, PRIVATE MALPRACTICE INSURANCE HAS BEEN AN INSIGNIFICANT FACTOR IN MASSACHUSETTS FOR OVER TEN

YEARS. SINCE THE LAST MEDICAL MALPRACTICE CRISIS IN 1975, MOST OF OUR PHYSICIANS AND HOSPITALS HAVE BEEN INSURED BY A STATE-CREATED NONPROFIT INSURER CALLED THE JOINT UNDERWRITING ASSOCIATION ("J.U.A."). THE JUA'S RATES ARE SET BY THE COMMISSIONER OF INSURANCE, AT A LEVEL WHICH DOES NOT INCLUDE ANY PROFIT AND WHICH INCLUDES A DOLLAR-FOR-DOLLAR CREDITING OF ALL INVESTMENT INCOME TO THE INSURED PHYSICIANS. THE RATES ARE SET IN LENGTHY EVIDENTIARY HEARINGS IN WHICH INTERVENORS SUCH AS THE MASSACHUSETTS MEDICAL SOCIETY ARE FULL PARTICIPANTS.

BECAUSE OF THE EXISTENCE OF THIS STATE-CREATED, NONPROFIT ENTITY, WE WERE ASSURED OF TWO THINGS: WE KNEW FROM THE RATE HEARINGS THAT THE TREMENDOUSLY INCREASING PREMIUMS WERE DUE TO INCREASED CLAIMS FREQUENCY AND AMOUNT, AND NOT TO INSURANCE COMPANY PROFITS (AS SOME NATIONAL GROUPS HAVE CLAIMED), AND WE ALSO KNEW THAT THROUGH THE RATE MECHANISM EVERY SAVING ARISING FROM OUR REFORMS WOULD BE IMMEDIATELY REFLECTED IN THE INSURANCE RATES.

HOWEVER, DESPITE THIS ADVANTAGE OVER OTHER STATES WHICH HAVE FACED SIMILAR PROBLEMS, THERE WERE STILL IMPROVEMENTS WE COULD MAKE TO THE INSURANCE SYSTEM. THESE INCLUDED BETTER RISK MANAGEMENT ACTIVITIES, A SYSTEM OF SURCHARGES AND CREDITS BASED ON A PHYSICIAN'S INDIVIDUAL EXPERIENCE, AN IMPROVED RATE SETTING MECHANISM AND INCREASED INSURANCE DIVISION RESOURCES IN THIS AREA. ALL ARE PROVIDED FOR IN THE MASSACHUSETTS REFORM BILL.

THE THIRD MAJOR AREA OF REFORM WAS OUR SYSTEM OF COMPENSATING WRONGFULLY INJURED PATIENTS--OUR LEGAL SYSTEM. WE HAVE A LEGAL SYSTEM THAT IS SLOW, COSTLY AND OFTEN NOT EVEN FAIR. OF THE PREMIUM DOLLAR, ONLY ABOUT 34 CENTS ENDS UP IN THE HANDS OF THE INJURED [illegible]. THE REST GOES TO PAY THE SYSTEM'S OVERHEAD--PRIMARILY LAWYER'S FEES ON BOTH SIDES. OVER 60 PERCENT OF THE INJURED PEOPLE IN OUR SYSTEM RECEIVE NOTHING, AND THOSE THAT DO RECOVER WAIT YEARS FOR THEIR COMPENSATION. MOREOVER, UNDER THE CONTINGENT FEE SYSTEM, AN INJURED PERSON MUST RECOVER AN ADDITIONAL 50 PERCENT OR MORE FOR "PAIN AND SUFFERING" ABOVE HIS OUT OF POCKET DAMAGES SIMPLY TO BREAK EVEN AFTER PAYING HIS LAWYERS. THAT SITUATION WAS ONLY MADE SLIGHTLY MORE PALATABLE BY THE COMMON PRACTICE OF "DOUBLE DIPPING", UNDER THE "COLLATERAL SOURCE" RULE, THAT IS, COLLECTING DAMAGES FOR EXPENSES THAT WERE ALREADY PAID BY HEALTH INSURERS AND WAGE CONTINUATION PLANS, WITHOUT REPAYING THOSE INSURERS AS REQUIRED UNDER OUR SUBROGATION LAWS.

FROM THE PHYSICIAN'S POINT OF VIEW, MOREOVER, THE LEGAL SYSTEM WAS CAUSING SERIOUS PROBLEMS. OBSTETRICIANS FACED, IN ESSENCE, A 21-YEAR (OR LONGER) LIMITATIONS PERIOD FOR BIRTH INJURIES, BECAUSE PATIENTS COULD WAIT UNTIL THREE YEARS AFTER THEY BECAME LEGAL ADULTS TO SUE. UNLIMITED "PAIN AND SUFFERING" AWARDS WERE ADDING COST TO THE INSURANCE SYSTEM BOTH BECAUSE OF THE ABSOLUTE LEVEL OF POTENTIAL AWARDS AND BECAUSE THEY WERE UNPREDICTABLE.

OUR REFORMS TO THE LEGAL SYSTEM CONSTITUTED A MODERATE ATTEMPT TO BALANCE THE NEED TO REDUCE COSTS AND STABILIZE THE SYSTEM WITH THE NEED OF GENUINE VICTIMS OF MALPRACTICE FOR FAIR COMPENSATION. THE PRINCIPAL CHANGES TO OUR TORT SYSTEM WERE PARTIAL REPEAL OF THE COLLATERAL SOURCE RULE, TO PREVENT DOUBLE COMPENSATION FOR PAST OUT OF POCKET COSTS; A $500,000 LIMIT ON NONECONOMIC, "PAIN AND SUFFERING" DAMAGES, BUT WITH A RELATIVELY BROAD EXCEPTION FOR EXTRAORDINARY CASES; A GRADUATED LIMIT ON ATTORNEY'S CONTINGENT

FEES, TO PUT MORE MONEY IN THE HANDS OF INJURED VICTIMS WHILE PRESERVING THE INCENTIVES FOR LAWYERS TO TAKE ON MALPRACTICE CASES, PARTICULARLY SMALL ONES; AND A SEVEN YEAR STATUTE OF REPOSE, REQUIRING ACTIONS BE BROUGHT WITHIN SEVEN YEARS OF THE ACT OF MALPRACTICE, BUT WITH A LONGER LIMIT FOR MINORS.

WE BELIEVE THAT BY ADDRESSING THESE THREE AREAS, MASSACHUSETTS CAN STABILIZE THE MALPRACTICE SYSTEM, DECREASE PREVENTABLE MALPRACTICE AND STILL PROVIDE REASONABLE COMPENSATION TO THE VICTIMS OF MEDICAL MALPRACTICE.

ON A MORE GENERAL VEIN, HOWEVER, BASED ON OUR EXPERIENCE WITH MEDICAL MALPRACTICE AND OTHER LIABILITY AREAS, I WOULD URGE THIS COMMITTEE TO EVALUATE CAREFULLY THE DESIRABILITY OF FEDERAL INTERVENTION IN THIS AREA. IN PARTICULAR, MANY ASPECTS OF MEDICAL MALPRACTICE APPEAR TO BE MORE SUITED TO STATE-BY-STATE REFORMS RATHER THAN FEDERAL MANDATES. FOR EXAMPLE, IN MASSACHUSETTS IN ADDITION TO A UNIQUE INSURANCE SITUATION, WE HAVE IMPOSED BROADER CONSTRAINTS ON PHYSICIAN REIMBURSEMENT THAN MANY OTHER STATES. MASSACHUSETTS ALSO DOES NOT GENERALLY ALLOW PUNITIVE DAMAGES, AS MANY OTHER STATES DO. AS A RESULT OF ITS UNIQUE SITUATION, MASSACHUSETTS MAY WELL HAVE STRUCK A DIFFERENT BALANCE OF EQUITIES THAN OTHER STATES WOULD HAVE REACHED WHEN FACED WITH A SIMILAR ISSUE. AS OUR EXAMPLE SHOWS, MEDICAL MALPRACTICE INSURANCE VARIES WIDELY FROM STATE TO STATE. PREMIUMS ARE SET ON A STATE-BY-STATE BASIS. MOREOVER, THE PRACTICE OF MEDICINE IS SUBJECT TO EFFECTIVE LOCAL REGULATION, MUCH MORE SO THAN MORE TRADITIONAL AREAS OF INTERSTATE COMMERCE. PHYSICIAN COMPETENCE HAS TRADITIONALLY BEEN A PRIMARY GOAL OF STATE BOARDS OF REGISTRATION. A PERVASIVE FEDERALLY [illegible] REQUIREMENTS IN THIS AREA MIGHT TEND TO IGNORE THE [illegible] SITUATIONS EXISTING IN EACH STATE, MAY DISCOURAGE IMAGINATIVE AND CREATIVE NEW DEVELOPMENTS THAT INDIVIDUAL STATES WOULD BE WILLING TO TRY, AND MAY EXACERBATE PROBLEMS IN ONE STATE WHILE IMPROVING THINGS IN ANOTHER.

HOWEVER, WE WOULD ENCOURAGE CONGRESS TO EXPLORE WAYS THAT THE FEDERAL GOVERNMENT CAN IMPROVE THE QUALITY ASSURANCE ASPECTS OF STATE MEDICINE BOARDS. FEDERAL ACTION COULD ASSIST IN DEVELOPING NATIONWIDE SHARING OF PHYSICIAN DISCIPLINARY AND PERFORMANCE DATA, TO REDUCE THE PROBLEM OF INCOMPETENT PHYSICIANS MOVING FROM STATE TO STATE TO REMAIN IN PRACTICE. THE FEDERAL GOVERNMENT, THROUGH GRANTS AND START UP PROGRAMS, COULD IMPROVE THE STAFFING OF STATE BOARDS, AND PERHAPS PROVIDE TRAINING COMPARABLE TO THE FDIC'S TRAINING OF STATE BANK EXAMINERS. THE FEDERAL GOVERNMENT, AS THE LARGEST PURCHASER OF HEALTH CARE, COULD PLAY AN INSTRUMENTAL ROLE IN DEVELOPING RISK MANAGEMENT AND QUALITY ASSURANCE PROGRAMS. I WOULD URGE YOU TO EXPLORE THESE AREAS AS POTENTIALLY FAR MORE EFFECTIVE FEDERAL INVOLVEMENT THAN IMPOSING NATIONWIDE MEDICAL MALPRACTICE LIABILITY STANDARDS.

IN CONTRAST, OTHER AREAS OF THE LIABILITY CRISIS MAY BE MORE SUITABLE FOR DIRECT FEDERAL RESOLUTION. PRODUCTS LIABILITY IN PARTICULAR WOULD LEND ITSELF TO A UNIFORM NATIONAL APPROACH. MANUFACTURERS NOW FACE 50 DIFFERENT STANDARDS OF LIABILITY, AND IT IS UNCLEAR THAT LEGAL CHANGES ENACTED IN ONE STATE WILL HAVE A MATERIAL IMPACT ON INSURANCE AVAILABILITY OR COST FOR INTERSTATE INDUSTRIES.

CONGRESS SHOULD ALSO EXAMINE THE QUESTION OF FEDERAL VERSUS [illegible] REGULATION OF THE INSURANCE INDUSTRY. THE PARTIAL EXEMPTION OF INSURERS FROM THE ANTITRUST LAWS, FOR EXAMPLE, IS A PURELY FEDERAL QUESTION THAT SHOULD BE SCRUTINIZED. DIRECT FEDERAL INSURANCE REGULATION IS ANOTHER. WITH INCREASINGLY COMPLEX INSURANCE AND FINANCIAL MARKETS, AND A TRULY NATIONAL OR INTERNATIONAL INSURANCE INDUSTRY, INDIVIDUAL STATE INSURANCE DEPARTMENTS MAY LACK THE RESOURCES OR ABILITY TO EFFECTIVELY REGULATE CERTAIN INSURANCE ACTIVITIES. INDIVIDUAL STATES MAY ALSO LACK THE LEVERAGE TO BE ABLE TO IMPOSE REGULATORY LIMITS ON INSURERS IN THE FACE OF THREATS TO WITHDRAW ENTIRELY FROM A STATE. MOREOVER, THE INTERNATIONAL REINSURANCE MARKET IS NOT SUBJECT TO EFFECTIVE REGULATION BY ANY STATE, NOR IS IT REGULATED FEDERALLY.

THE FEDERAL GOVERNMENT HAS HAD A NEGLIGIBLE ROLE IN INSURANCE REGULATION UP TO NOW. THAT SITUATION SHOULD AT LEAST BE LOOKED AT IN VIEW OF THE PRESENT NATIONWIDE DISRUPTIONS OF THE INSURANCE MARKETS.

FINALLY, I WOULD ALSO URGE YOU TO BE SKEPTICAL OF ACROSS-THE-BOARD SOLUTIONS. REFORMS MUST BE TAILORED TO THE PARTICULAR PROBLEM OR INDUSTRY AFFECTED. WHAT MAY WORK FOR MEDICAL MALPRACTICE MAY NOT MAKE ANY DIFFERENCE AT ALL TO A MUNICIPALITY OR A DAY-CARE CENTER OR A MANUFACTURER. MOREOVER, THE PUBLIC POLICY BEHIND REFORMS IN ONE AREA MAY BE DRAMATICALLY DIFFERENT IF THOSE REFORMS ARE SUGGESTED IN ANOTHER CONTEXT.

I COMMEND YOU FOR YOUR CONCERN WITH THE MEDICAL MALPRACTICE ISSUE AND OTHER ISSUES OF LEGAL LIABILITY, AND I URGE THAT YOU CAREFULLY TAILOR ANY RESULTING FEDERAL LEGISLATION TO AREAS CALLING FOR A FEDERAL RATHER THAN STATE SOLUTION, AND STRUCTURE ANY FEDERAL REMEDIES TO SPECIFIC INDUSTRIES OR AREAS OF LIABILITY IN WHICH THOSE REMEDIES WILL HAVE MEANINGFUL, DEMONSTRABLE RESULTS.

THANK YOU.

Mr. RYAN. Ms. Gold, thank you for your thoughtful testimony.

I would like to recognize Senator Kerry from the Commonwealth of Massachusetts who has arrived, and I would like to turn the Chair over to Senator Kerry.

Senator Kerry [presiding]. Thank you very much.

I am delighted to be here, and I am very apologetic to all the panels for being late. I guess everybody has come to understand that this process puts us on 16 different committees with 36 different subcommittees all meeting at the same time, and there is a craziness to it, which is reflected often in who can get where.

But I am also particularly sorry because Paula Gold is a very good and close friend. I had the privilege of serving in the same cabinet with her in Massachusetts when I was Lieutenant Governor and have known her when she was managing one of the most important departments in the attorney general's office, and her record in the State of Massachusetts is extraordinary, and I recognize her personally as really one of the best public servants in the State and also clearly an expert with respect to this issue.

So I am delighted to welcome her, and I look forward to the rest of the testimony and then subsequently coming back and asking some questions.

And also, please accept my apologies to the first panel and to Dr. Rockett, from Newton, MA, which happens to be my home. Here we are, Massachusetts day in the committee, and I am only just getting here.

But anyway, let us go on, and then I would like to ask a few questions. So why don't we proceed now with Mr. Wester.

Mr. WESTER. Good morning, Senator, ladies and gentlemen.

I am Gerald Wester, deputy insurance commissioner for the State of Florida. The medical malpractice issue dominated the 1985 Florida Legislature nearly to the extent that the broader liability insurance crisis dominated our 1986 session.

Florida's approach to medical malpractice focused on three areas: prevention of malpractice, equitable and timely resolution of injury, and of course, reduction of cost. We set as our task to achieve the best balance of these goals. I cannot say that Florida now has the whole answer, either on the issue of medical malpractice or on the broader issue of liability as a whole. But I would like to provide you with just a brief overview of our efforts and share with you some of our experiences.

In 1985, we looked at a so-called no-fault insurance proposal for medical malpractice. Our findings, based on the best information we had available at the time, was that such a system would have been three times more costly than the current tort system.

So we began to look more closely at the other end of the equation. We looked at prevention; medical malpractice risk management, if you will. And as a result, today Florida is the only State in the Nation which requires hospitals to have so-called certified health care risk managers on their staffs. These managers are licensed and must meet certain education and experience requirements.

Our law places certain requirements on these managers, and the whole idea was to put greater responsibility on the hospitals to somehow police their staff physicians.

In addition, as part of the licensing requirements of hospitals, they must maintain risk management programs, including documenting of frequency and causes of adverse instances and annual risk management training of their staff. Hospitals must submit adverse incident or medical malpractice reports to our Florida Department of Health and Rehabilitative Services, which has the authority and the responsibility to investigate the reports as to possible disciplinary action.

The provisions of our law also strengthen physician review and disciplinary action and require risk management education for physicians.

Our efforts in Florida help stress the need for adequate, equitable and timely delivery of compensation to the injured victim. Any system that shifts the cost of compensation away from those who cause the injury would be a step backward in our opinion.

If the issue of fault is removed, we cannot successfully remove the malpracticing physician from the system, and we cannot bring about changes in the hospital setting to reduce the risk of future injuries.

Our main goal in revising our laws governing liability suits was to encourage out-of-court settlements to reduce cost and time for victims to be compensated for injuries. To encourage prompt settlement of meritorious claims, our law requires a claimant to give notice of intent to litigate 90 days prior to filing suit; it allows judges to require pretrial settlement conferences and imposes penalties for the rejection of reasonable settlement offers.

Other changes in our tort system include a partial repeal of the so-called doctrine of joint and several liability, limit on noneconomic damages of $450,000, punitive damages care limited to three times the jury verdict. There are also provisions designed to reduce frivolous lawsuits and provisions to allow parties found liable for economic damages to structure or make periodic payments.

Whatever the impact these changes have on the cost of medical malpractice and consequently on medical malpractice insurance, a key need in the insurance market is stability. The recent roller-coaster ride of rate increases in the entire liability insurance marketplace constitutes a crisis in itself, even beyond just the basic cost of insurance. That is why one of the most significant parts of the legislation that we passed in Florida addresses rate regulation.

Another part of that law addresses the issue of so-called excess profits. Under the new law, excess or windfall profit realized by insurers over a period of years will be returned to policyholders with the condition that those policyholders have an improved program of risk management in place.

Insurance regulation is a role the States themselves can and should undertake. The environments, legal and economic, in each State are significantly different. Regulation of health care facilities and tort laws differ from State to State; so must regulation of the insurance industry differ.

However, I do believe that the Federal Government can work with States to solve many of the problems we are currently facing, and we in Florida, will continue to make ourselves available to help in reviewing the needs of the insurance marketplace and working with the Senate and the Federal Government to make the liability insurance marketplace stable and more accessible.

I will be glad to answer any questions.

Senator KERRY. Thank you very much, Commissioner. I appreciate you comments.

[The prepared statement of Mr. Wester follows:]

Statement to the Senate Labor & Human Resources Committee

By Gerald Wester, Deputy Insurance Commissioner, Florida

September 11, 1986

The important issues that we in Florida see in the area of medical malpractice are really very simple: they are 1) prevention of medical malpractice; 2) equitable resolution of injury; and 3) cost.

Over the last several years, we have been working to achieve the best balance of those ends. I cannot say Florida now has the whole answer, either on the issue of medical malpractice, or on the broader issue of liability as a whole.

But our efforts have been going forward on the basis of those three points. In 1985, Florida looked at a no-fault proposal for medical malpractice. Our finding~~s~~, based on the best information we had available, ~~were~~ was that such a system would have been more costly in administration than what was currently on the books.

So we began to look more closely at the other end of the equation. We looked at prevention. Medical malpractice risk management if you will. And as a result, today Florida is the only state in the nation ~~with~~ which requires hospitals to have certified health care risk managers in its hospitals.

This is not to deny that changes are needed in the tort system. We need to make sure that there is a proper match of compensation for injury, real responsibility and severity of injury. But we need to be sure that we look very closely at such changes to see that they are indeed an improvement. We need to make sure we're paying the right people the right amounts for the right reason.

We in the Florida Department of Insurance do not oppose any system which improves the adequate, equitable and timely delivery of compensation to the injured victim. We are opposed to any system that shifts the cost of compensation away from those who caused the injury. If the issue of fault is removed, we cannot successfully remove the malpracticing physician from the system, and we cannot bring about changes in the hospital setting to reduce the risk of future injuries.

Whatever the legitimate costs of medical malpractice -- and consequently of medical malpractice insurance -- a key need in the market is stability. This is true for the insurer as for the insured. The recent rollercoaster ride of rate increases in the entire liability insurance marketplace constituted a crisis in itself, even beyond the issue of cost.

That's why one of the most significant parts of the legislation that we passed in the 1986 Florida Legislature addresses rate regulation. It may be that rates must rise. It may be that the current tort system is too expensive. But without adequate review of the facts that go into insurance prices, little can be done in the way of public policy on the tort system.

Another part of that law addresses the issue of excess profits. Under the new law, excess or windfall profits taken by insurers over a period of years will be returned to the policyholder with the condition that the policyholder has an approved program of risk management in place.

We heard voices in the industry that deplored the frenzy of rate cutting that took place a few years ago and predicted the current crisis. Many industry voices now say the industry is moving into one of the most profitable phases of its history. In either case, events have been apparently outside the control of the industry itself. It is an important role that government can play to provide the market with a rational basis for pricing decisions.

This it is a role the States themselves can and should undertake. The environments, legal and economic, in each state are significantly different. Regulation of health care facilities, and inevitably tort laws differ from state to state. So must regulation of the insurance industry differ.

It is not a rapid process. States like Florida that have often been on the cutting edge of insurance regulation must often test the waters, sometimes alone. Eventually, a good idea is adopted by most of the states to whose situation it applies.

I believe federal government can work with the states to solve many of the problems the insurance industry faces. Earlier this year, Florida Insurance Commissioner Bill Gunter spoke before the Senate Commerce Committee to suggest reinstatement of the subchapter S corporation tax provisions that were so beneficial to the reinsurance market before they were repealed.

We in Florida will continue to make ourselves available to help in reviewing the needs of the insurance marketplace and in working with the Senate to make the liability insurance marketplace stable and accessible.

I would be glad to answer any questions you may have.

Senator **Kerry**. Let me ask both of you—I used to practice in medical malpractice when I was in private practice, and a lot of friends of mine still are, and they tell me that close examination of insurance companies shows record profits, shows not an enormous marginal difference in payout versus revenues, particularly in terms of settlements, et cetera.

Do either of you have any findings to the degree that this thing is getting overhyped and a little out of fundamental relationship to reality?

Ms. **Gold**. I can state that in Massachusetts, we do not have private companies that write medical malpractice. And because we have a JUA, basically a nonprofit State entity that was created by the legislature in 1975, we were able for years to have some of the lowest rates in the country.

The rates in Massachusetts go into effect only after lengthy, protracted hearings, and at those hearings, investment income and profits are part of it. I think it is very difficult to generalize across the whole system. Clearly, what happened in Massachusetts was we have an increase in claims and an increase in payout, and we have an increase in projected payouts, and that is why we took the legislative action we have taken.

On the other hand, in terms of liability in general, I do not think there is any question that the insurance industry overall is profitable. That alone does not necessarily answer the question. There are a number of companies in the past few years who have gone bankrupt and into receivership, and they are primarily the companies that have written certain lines which major companies did not write.

In saying that, I think it highlights the fact that one has to look carefully at the individual areas, and therefore across-the-board solutions, I do not think are really in order. Basically, that is what is contained in the testimony.

Senator **Kerry**. Did you want to comment on that, Mr. Wester?

Mr. **Wester**. I think I would agree that overall, in all your liability lines, there is a certain amount of profits going on. I think I would also agree that once you get that down to medical malpractice, there are some problems; there are a limited number of carriers. We have seen some of the same problems with insurance companies with our so-called self-funded trusts which have been authorized in Florida since 1976, where the physicians can band together and provide their own insurance needs. They have experienced similar problems as far as loss increases, et cetera, that the insurers have.

But I think there is definitely a feeling on our part that some carriers have taken advantage in the last couple of years of the availability problem and certainly have somewhat overpriced their products. That is the reason we have put in place a number of things, to receive the kind of data so that we can get a handle on that situation and also have greater control over the rates. And on the back end, we do have an excess profit law now.

Senator **Kerry**. Is there one more critical component of stemming the increase in rates than others, let us say—I mean, the joint and several liability or the frivolous suit issue? Is there one that stands out over others, or is it really a conglomerate?

Mr. WESTER. It was testified numerous times in Florida that joint and several liability would have very little impact on rates. I think joint and several is more of a fairness argument. It certainly will benefit the big utilities and other large industries with large exposures and who are targeted as the "deep pockets." But so far as your doctors, and so far as your mom-and-pop businesses, it was testified several times that joint and several would have very little impact on the cost of insurance to them.

Frankly, we were somewhat disappointed, even though the insurance industry and our professions and our business interests for the last 2 years have touted the different tort reform measures as the solution, or at least the primary solution, none of them have come forth with the kind of data that we felt like we needed to make an informed decision as to exactly what impact to it reform would have. We asked for it repeatedly, our legislature asked for it repeatedly. One of the measures that we did put in place was mandatory closed claims reporting, not only from the insurance industry itself but also from our health care providers, so that hopefully, we can make an evaluation on what really does need to be done. But we simply did not have the kind of data that we felt like we could make an informed judgment.

Senator KERRY. Does the McCarran-Ferguson Act from your perspective give too much freedom to the insurance companies? Do you think we should review some possibilities of changes in that?

Mr. WESTER. Our reading of the act—and maybe we are reading it wrong—is that it does not preclude the Federal Government currently from coming in if they feel like there is collusion or companies are acting in concert. We feel like the Federal Government has that ability now.

Senator KERRY. Do you think there is collusion at all today?

Mr. WESTER. We do not have any evidence of collusion.

Senator KERRY. No evidence.

Mr. WESTER. We think they follow each other. Whether that is collusion or not, I do not know.

Senator KERRY. Let me ask you also, Ms. Gold, in your testimony you talked about the Federal Government relationship here, and you suggested, I think, that we ought to be looking at product liability and antitrust provisions. Do you want to comment further on that?

Ms. GOLD. I think that the antitrust exemption should be relooked at, and that has been recommended in the past. And I think some role in terms of general overall regulation of the insurance industry should be looked at. I think there is a lot the States can do very well in terms of the people of their State in regard to the insurance industry.

I even have concerns about how able States are to guarantee safety and soundness of companies with a diversity of products. We are in a different day and age in terms of the insurance industry now, and a very thoughtful reexamination of the way we regulate should be undertaken.

Yesterday's regulations may not meet today's market conditions, and this is independent of whether or not we have or do not have a crisis in terms of liability insurance.

Other suggestions in terms of medical practice which I do think is something that the States, in terms of their tort systems can handle—and again, I pointed out Massachusetts is just uniquely different, so what we came up with in terms of a solution may be very different than other States. We can predict that our tort reforms will bring about rate stabilization and will have a rate impact, because there is no private competitive market, basically, in Massachusetts.

On the other hand, we are trying to implement the medical malpractice legislation now with the medicine board, and we just named an advisory committee to deal with minimum standards of care. Well, that is a kind of generic issue that we could use a lot more expertise on and which I think the Federal Government could assist medicine boards; how to make medicine boards really effective monitoring agents, I think, is extremely important and best done on a State level though with Federal backup, as well as the sharing of information. If a physician leaves one State and goes to another, and there is not adequate sharing of information, we can have serious problems—and we did in Massachusetts have serious problems. It was a case of physical abuse; it was not medical malpractice, but the whole pattern of complaint in another State that had never been reported to our medicine board, not because of the States fault, but because there are not systems in place.

So I think there is a role for the Federal Government in those areas, and the area of product liability is not susceptible to solutions, if you think there are solutions necesary in a State.

Senator Kerry. I understand that.

Ms. Gold. It is priced on a national basis, as opposed to municipal liability which is, as opposed to charitable which is—anything that is wholly within your borders, we should be able to handle, and I think that should be left to the States. But that which is not wholly within our borders and which we cannot really have any impact on or which we do not have enough resources or expertise, I think there is a role for the Federal Government.

Senator Kerry. I think we have a product liability bill that is currently wandering through here, and it is supposed to get to the floor soon, and as it comes, I will think about the comments you have just made with respect to that bill and see if that is covered. I am not familiar with whether it is now or not.

The other thing I want to say is that with respect to the risk management suggestions and the general quality of assurance programs, I would like to have the opportunity to have the record reflect perhaps a greater discussion on that, and I do not want to create work but if we could submit just a couple questions in writing in order to extend that for the record purposes, I think it would be helpful to us as we go at it. And what I would like to do as we close the hearing is leave the record open for 2 weeks for colleagues of mine to be able to also submit questions if they would like to to any of the panels and additionally, should there be any other responses which any panelist would like to make, they can do so in the course of that time. So the record will remain over for 2 weeks, and this hearing will stand adjourned.

[Additional material submitted for the record follows:]

american society of internal medicine

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September 25-28, 1986

REPRESENTING
Internists and
All Subspecialists
of Internal Medicine

September 22, 1986

BY HAND

Mr. Bill Ryan
Chief Counsel
Labor and Human Resources Committee
Room 428
Dirksen Senate Office Building
Washington, DC 20510

Dear Mr. Ryan:

Please find enclosed a copy of the American Society of Internal Medicine's (ASIM) Position Paper on the Professional Liability Crisis. Please include it in the official record of the September 11 hearing on the impact of the medical malpractice insurance crisis on health care in America. ASIM is a national organization consisting of physicians who are recognized as specialists in internal medicine. The Society is interested in the social, economic, and political factors affecting the ability of internists to deliver high-quality patient care.

Please let me know if ASIM can be of further assistance.

Sincerely,

Richard Trachtman

Richard L. Trachtman
Government Affairs Representative

RLT:srl
G-RT-0091
Enclosures

1101 VERMONT AVENUE NW • SUITE 500 • WASHINGTON, DC 20005-3457 • TELEPHONE (202) 289-1700

AMERICAN SOCIETY OF INTERNAL MEDICINE
POSITION PAPER
ON THE
PROFESSIONAL LIABILITY CRISIS

February 1986

Overview of the Problem

Medical professional liability is now as it was in the mid-1970s one of the single most important issues facing the medical community. While the crisis of 10 years ago was primarily one of "availability," physicians are now dealing with what is frequently described as a crisis of "affordability" and how it has affected access to as well as the cost and adequacy of quality medical care.

Internists and internal medicine subspecialists are being adversely affected by the crisis although not to the degree of other high risk specialties. Naturally many of the problems of the professional liability crisis are common to all physicians such as escalating professional liability premiums which add significantly to overhead expenses (in a time when many factors such as Medicare are forcing physicians to hold the line on fees) and the increasing practice of defensive medicine which adds an estimated $15 billion to the nation's overall cost of medical care.

While there are some groups such as the American Trial Lawyers Association who still question whether a crisis truly exists, the problem has been well-documented by others. According to the A. M. Best Company, independent analysts of the insurance industry, medical malpractice losses (including loss expenses incurred) have been higher than premiums earned since 1980. This loss ratio (claim losses plus loss expenses divided by premiums) was 150% in 1982 and 142% in 1983.[1] To some extent this loss as been ameliorated by investment income (interest generated by premiums until they are utilized) but even then claim losses and loss expenses have exceeded total income.

Any evaluation of how the insurance industry is performing in the medical professional liability line of business must not be limited to an examination of premiums to "paid losses" but must also include the millions of dollars spent by insurance companies in overhead, in adjusting losses, in defending physicians against claims without merit and paying company expenses and taxes.

The liability "crisis" is not limited just to medical practitioners. Rather the problem has affected a broad range of society. Skyrocketing awards have been occurring in product liability cases with their attendant costs being passed on to consumers. Some drug manufacturers have ceased producing childhood vaccines because it is virtually impossible to obtain the liability insurance necessary to stay in the market. The cost of professional liability insurance for architects and engineers is also increasing dramatically and, in some instances, the coverage is unavailable. Municipalities are having difficulty obtaining liability insurance and some are operating without it because they refuse to pay the premium that insurers are demanding or their insurers have dropped them. Further, there is evidence that many outside corporate directors are leaving their positions because their companies cannot maintain directors and officers liability insurance. If corporations maintain all-inside boards, questions obviously arise as to who is serving the shareholders.

Insurance companies are dramatically increasing rates because of their deteriorating financial position in underwriting medical professional liability insurance. Premiums vary dramatically from state to state. While average premiums for internists increased from approximately $2400 to $4400 from 1978 to 1983,[2] there are some areas of the country where annual premiums exceed $10,000.

While some argue that a few consistently negligent physicians have had a substantial impact on losses paid, the evidence shows that repeat offenders are not the problem. The fact is that most medical malpractice claims do not involve negligence. An estimated three out of four cases are ultimately settled in the provider's favor, but it is the high cost of defending claims that is also contributing to the dramatic rise in premiums.

The average physician risk of incurring a medical malpractice claim has increased nearly threefold since 1980. The incidence of claims filed against internists increased from 2.4 claims per 100 physicians prior to 1980 to 5.7 claims during the following five years.[3] An analysis of 1983 claims experienced by the 23 physician-owned medical professional liability insurance companies by the American Medical Assurance Company (AMACO), an American Medical Association subsidiary that provides reinsurance to the companies, shows that the incidence of claims has risen to 20.3 claims per 100 insured physicians. In other words, one in five physicians will be sued this year.

Claims loss severity is also increasing at an alarming rate throughout the country. Jury Verdict Research of Solon, Ohio, reports that the average medical malpractice verdict (including million dollar verdicts) in 1975 was $220,018 but by 1984 the average had risen to $666,123. In 1975 there were 3 verdicts over $1 million while in 1984 there were 71 verdicts over $1 million.

The legal system does not deal with physicians fairly. Based on a study released in 1985 by the Rand Corporation's Institute for Civil Justice, the Institute found that jurors were much more sympathetic to plaintiffs injured in medical malpractice cases than plaintiffs with the same injury that occurred on property, at work or in connection with product liability cases. Malpractice awards were as much as five times higher than injury-on-property cases.

Some experts believe that the practice of defensive medicine (the ordering of additional tests in anticipation of a medical malpractice lawsuit) may have more of an impact on health care costs than professional liability premiums. Equally, there are experts who believe that defensive medicine is simply the increased care which the malpractice system is intended to encourage and that it is not possible to distinguish defensive medicine from the overutilization that results from the economic incentives inherent in fee-for-service medicine.[4] Some defensive medicine is described as simply good medical practice. Various surveys have shown, however, that defensive medicine unquestionably is on the rise.

Indeed, surveys have shown that internists are keeping more detailed records, ordering more tests, obtaining more consultations, and are referring patients to other specialists more frequently.[5] In turn, the price of health insurance is increasing employee medical expenses thereby placing economic pressures on employers to implement cost-sharing features in their employee health benefit plans. Ultimately, the consumer of health care pays the price.

By-Products of the Problem

Although many experts believe that a good doctor-patient relationship will lead to fewer suits, the fear of a malpractice claim is causing some internists to maintain a more businesslike, "arms length" relationship with patients. No matter how good the rapport is between a patient and doctor, paranoia about malpractice and the fear of a lawsuit, especially for those who have been sued at least once, is affecting doctors' behavior around their patients.

Another area where the public as much as the provider suffers is with regard to the inefficiencies of the legal system itself. Patients who are injured because of their treatment deserve to be compensated promptly and fairly. The current legal system does not permit such a luxury because medical malpractice cases often take years to resolve. Fully one-third of all claims take more than two years to resolve, and even then, only 28 to 40 cents on the dollar (with some estimates as low as 20 to 25 cents) is returned to plaintiffs as compensation. The rest goes to attorneys and insurance companies to cover costs such as administration, claims evaluation and litigation costs.[6]

While the purpose of a lawsuit is to seek compensation for victims of malpractice and deter substandard care through the threat of legal action, there is one result that is often overlooked--the effect a lawsuit has on a physician from a personal standpoint. It has been shown that most physicians who are sued find that it is enormously disruptive to their personal and professional life. Many physicians who have been sued suffer from symptoms indicative of depression and stress which, in the long run, is likely to have an impact on the ability of the physician to deliver quality health care.[7] Medical liability lawsuits have also served as an incentive for some physicians to leave their practice or to retire at earlier ages resulting, in some cases, in the reduction in availability of care.

Tort Reform

Tort reform is not the ultimate answer to the medical malpractice problem. To the contrary, there are some tort reforms that have done little to reduce medical liability costs and others that simply have not had the effect that was originally intended. There are a few reforms, however, that when carefully drafted, can go a long ways towards reducing medical liability costs. This, in turn, would benefit patients by lowering costs and by ensuring the availability of liability insurance and, hence, availability of health care services.

Moreover, there are some states where the professional liability problem is not as serious as in others. For this reason, individual states are in the best position to determine the need for legislative relief. The following reforms are among those which have been demonstrated to provide measurable claims savings and hence a reduction in the costs of the medical malpractice system:

- Limitation on awards for non-economic damages (pain and suffering, mental anguish and loss of consortium).

- Elimination of the collateral source rule to prevent double compensation to plaintiffs. (The collateral source rule prohibits introduction of evidence of information about compensation that a plaintiff may receive from sources other than the defendant; e.g., reimbursement from a health insurance policy or workers' compensation plan for medical expenses.)

- Periodic payment of damages to eliminate windfalls to the heirs of plaintiffs who die earlier than anticipated and to more appropriately compensate patients with lifetime disabilities.

- Attorney fee regulation to ensure that reasonable compensation will go to injured plaintiffs without denying attorneys fair compensation. Earlier settlements will be encouraged (and tactics intended to delay settlements discouraged) by removing incentives to seek larger awards and therefore larger fees.

- Elimination of punitive damages from professional liability lawsuits. Punitive damages are intended to punish the wrongdoer and this responsibility should be left to the state licensing boards, medical societies, hospital peer review systems and the criminal justice system.

Standards of Care

Medical malpractice is negligent care by a health care provider that causes injury to a patient. To be awarded damages for medical malpractice, the plaintiff must prove that the legal standard of care has been breached, that there was injury and that the injury was caused by such breach. Establishing the standard of care in court is left to expert witnesses and the applicable standard is usually drawn from observation of customary practice. Eighteen states have laws establishing a medical standard of care.

One of the most difficult problems in medical malpractice cases is determining the standard of care (Should a local, state or national standard apply?). And in an era of increasingly sophisticated medical technology, when physicians cannot always agree on medical procedures, it is questionable whether a judge or lay jury can decide this issue.

Cost containment programs (Medicare's Prospective Payment System, for example) by their very nature, create pressures to restrict care which may affect its quality. Appropriate data collection and analysis should enable physicians to reach agreement on many treatment schedules (known as protocols) that would probably be helpful to some physicians who face these pressures. Any cost containment program, however, devoted to the delivery of high quality cost effective medical care should be constantly vigilant that quality of care is not compromised. A balance must be maintained in the cost-quality equation.

Peer Review/Risk Management/Disciplinary Action

State medical societies and national medical specialty societies as well as hospitals should be encouraged to implement peer review and risk management programs to ensure quality care. While there is no clear proof that risk management programs reduce the likelihood of a lawsuit, at least one medical specialty society has developed a risk management program which is believed to have been the main reason for a reduction in premiums for their particular group.

State licensing boards should be encouraged to investigate cases of medical negligence and take disciplinary action where appropriate. Insurance companies should be required to make certain data available to state agencies to aid them in their investigations. State medical examining boards often have difficulty identifying the physicians generating multiple claims involving actual negligence because claims in this category are often settled "quietly." Historically, these boards have been ineffective in revoking licenses of physicians who have demonstrated recurring aberrant practice because of, among other factors, the fear of being sued by physicians whom they seek to discipline and also because of limited resources. Efforts should be made to provide these state licensing boards with adequate resources to handle the caseload of investigations. Moreover, hospitals and state medical societies should not only report examples of flagrant and recurring negligence to state examining boards, but also patterns of care which indicate inappropriate practice or that the physician in question may be marginal.

Consumer Education/Communication

The professional liability problem is not a reflection of the quality of medical care. Rather, the evidence suggests that quality has never been higher. Publicity about medical advances, however, has raised the public's expectations about medical outcomes. Consumers have come to expect perfect results every time treatment is rendered. Consumers need to understand that physicians are human and occasionally, because of events beyond their control, either an adverse result occurs, or the patient does not experience an outcome that is 100% perfect.

Consumers also need to be fully apprised of the fact that when they hear of the million dollar verdicts, it is the consumer who ultimately pays for them. As professional liability losses escalate, so do premium dollars and ultimately, fees to patients.

In an age of rapidly increasing medical technology, specialization and impersonal medical care, doctors also need to evaluate and strengthen their relationships with their patients. More effective communication between doctor and patient would enhance these relationships.

RECOMMENDATIONS

1. ASIM supports tort reform that encourages fair compensation to all deserving injured claimants or plaintiffs and prompt resolution of professional liability claims, and all personal injury claims.

2. ASIM believes that federal intervention may be necessary because of the magnitude of the problem, but also believes that states are in the best position to judge the seriousness of the problem and to implement appropriate legislative relief.

3. ASIM supports tort reform that accomplishes the following: limits awards for non-economic damages, eliminates punitive damages, eliminates the collateral source rule, and allows for periodic payment of damages. ASIM also supports tort reform which provides for attorney fee regulation in personal injury and medical malpractice cases.

4. ASIM supports the American Medical Association position regarding the concept of data collection and analysis to "correct inappropriate variations in treatment patterns and procedures."

5. ASIM encourages physicians' active involvement in peer review activities both at the medical society level and in hospital settings.

6. ASIM supports the development of risk management programs in hospitals as well as by specialty societies and state and local medical societies.

7. ASIM supports the strengthening of state licensing boards so they can more effectively investigate cases of medical negligence and take appropriate disciplinary action.

8. The public should be educated regarding expectations about medical outcomes and the effect the medical malpractice crisis is having on the cost, availability and quality of medical care.

9. Physicians should be encouraged to strengthen doctor-patient relationships to reaffirm the doctors' position as the patients' advocate.

/srl
A10-9349

Definitions

Loss Expense - The cost to the insurance carrier of defending, investigating and adjusting a claim.

Reinsurance - Insurance that is purchased by insurance companies to reduce the chance of any one loss or types of losses significantly affecting a company's financial position.

Tort - The breach of a legal duty imposed by law other than by contract. A wrongful act committed by one person against another person or his or her property. Most tort claims against professionals arise from allegations of negligence or failure to exercise the required standard of care.

Tort Reform - An effort to change state laws affecting liability lawsuits.

Collateral Source Rule - The arrangement whereby a jury or a judge is not privy to other sources of payment that may be available to the plaintiff such as health insurance payments. Thus, there may be a "double award" - an award from the jury covering hospital expense and a second payment from the plaintiff's insurance company covering the same item.

ENDNOTES

[1] Professional Liability in the '80s, Report 1, American Medical Association Special Task Force on Professional Liability and Insurance, October 1984, p. 8.

[2] What Legislators Need to Know About Medical Malpractice, Robert Pierce, senior research analyst, National Conference of State Legislators, based in part on presentations made at a national conference sponsored by The Urban Institute, February 1985, in Washington, D.C., entitled "Medical Malpractice: Can the Private Sector Find Relief?"

[3] AMA Socioeconomic Monitoring System (SMS) survey, 4th Quarter, 1984.

[4] "Evaluation of the Current Malpractice System," Patricia Danzon, presentation at the Urban Institute's national medical malpractice conference, "Medical Malpractice: Can the Private Sector Find Relief?" February 21-22, 1985.

[5] "What Doctors Are Doing About The Malpractice Threat," Physician's Management, September 1985, p. 69.

[6] Danzon, February 21-22, 1985, "Medical Malpractice: Can The Private Sector Find Relief?"

[7] "Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation," Sara C. Charles, MD, Jeffrey R. Wilbert, M.A., and Kevin J. Franke, M.A., American Journal of Psychiatry, 142:4, April 1985.

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NEW YORK LAW JOURNAL--Friday, May 30, 1986

What Happened to Fair Settlements?

By Paul D. Rheingold

Somewhere we have lost our way. As a plaintiffs' lawyer, I can say that to my bar (although surely not for it, considering my view). In recent years we have somehow become persuaded that it is our duty to try personal injury cases and to seek the highest possible verdicts using all legitimate means. We have been motivated by the canons of ethics which call for fidelity to a client's interests, but also by less than pure motives of making fees and attracting new business. We like to read about our big verdicts in the press and in the *Jury Verdict Reporter*.

Rising nobly to this challenge, the defense bar has thrown renewed efforts into fighting big verdicts and into trying every matter which was labeled "defensible" by some expert. More and more time and money (all paid by the insurance carrier) is poured into the defense, in order to beat down "phony claims." In turn, this produces more effort from the plaintiff's side, of course. Four experts are now consulted on each side. Costs escalate. Motions abound and cases are further delayed until resolution.

What Happened to Fair Settlements?

What we have lost sight of is that trials are intended to take place only when a lawsuit cannot be fairly resolved, and that "fairly" does not mean going to the mat every time (be it to get the last penny for the plaintiff or to assert an unreasonable "no-pay" stance from a carrier). Indeed, we have lost sight of the fact that lawsuits per se are only a last resort for a dispute which cannot be compromised amicably without starting suit.

In these days which are so perilous to the survival of the tort system, I do not believe that it helps much for each interest group to blame every other one. Rather, we are all to blame for the creation and maintenance of a system which threatens to become the sabre-toothed tiger, unable to survive due to over-development. What then can we do by way of change and accommodation to preserve our Anglo-American system of resolution of tort disputes? I offer a few suggestions, but really hope to stimulate discussion.

The Courts. Please be more aggressive as judges. We do not have the luxury of judges merely acting as umpires. Judges from the lower courts up must take an active role in litigation. This means willingness to grant summary judgments, directed verdicts, and JNOVs. It means managing trials and shaping verdicts.

Please try to return us to a fault-based system. Try to resist the appeal of our arguments that liability should e expanded. For example, in product liability let's hold m to the state-of-the-art defense. Let's keep municipal iability where it is today. As representatives of our lients, is it our job to "push the envelope," but you don't ave to go along with it.

Where the courts have fallen down most, it seems to e, is in their failure to examine verdicts closely enough n remittitur motions. The courts seem to feel that their ower of scrutiny arises out of the vague concept of hocks the conscience of the court." Perhaps the Court of Appeals must lead the way, but judges need to utilize more specific and objective criteria for evaluation of possible excessiveness. It is not the "big verdict" per se which must be cut down at all costs. Rather, $50,000 for a whiplash can be excessive, whereas $2 million for a quadriplegic may not. As much as I would have objected just a year ago to the concept, how about a declared practice of comparing the rendered verdict to prior verdicts for the same injury, or even making a comparison to the specials?

Defense Bar. Besides stopping the overworking of a file, please have the courage to join with the plaintiffs' bar in speaking out against the onslaught against victim's rights. The fear which you evidently have that you will lose accounts if you speak out for what you know is right will only harm you in the long run when the rights are lost. For when that goes and the plaintiffs' bar is practicing domestic relations law, you will have no accounts to lose.

Plaintiffs' Bar. Let's cool it, brothers and sisters! Let's stop those seminars and books on how to win big verdicts. (I recently received a brochure from the Association of Trial Lawyers of America promoting a program at a resort on Maui on how to win the big verdict.) Let's see what we can settle amicably without trying to get our names in the paper. Just a few more multi-million-dollar verdicts for psychics who lose their powers or subway suicides and we will see caps and other limitations on liability imposed upon our cases. Let's start making reasonable demands and hope that our defense counterparts will act more responsibly, too.

Also, let us recognize that some excesses have creeped into our system of reparations. Let us seek some compromise on the pending state legislation rather than continuing to deny that there is a crisis. We gain nothing by saying there is no crisis but only a perception of one. In 1986 the perception became the reality. We can live with some of their "reforms": termination of the collateral source rule, statutory definitions of liability, sanctions for frivolous suits, limits on fees on recoveries over a certain amount, even some modification of the joint and several liability rule (such as percentage caps on responsibility).

Let us also recognize that we don't always serve our clients best when we hold out for trial. We should stop to listen to our clients. Only rarely do they want to walk home millionaires. They have more humble and practical goals — recovering their specials, ensuring some means of future support. They are angry, and vindictive, to be sure, but it is we as their lawyers who perhaps advise them poorly when we channel every problem into the sole solution of the most money we can obtain for them.

All Lawyers. No doubt those of you who practice in fields other than personal injury are saying to yourselves, "Thank God they are not trying to legislate my field out of existence." Consider whether this is not shortsighted in light of the fact that we who will be driven out of our chosen field will go into other law lines.

Insurance Companies. If you succeed as well as you aspire on the destruction of our tort system, who will need your product?

Paul D. Rheingold is a partner in the Manhattan firm of Rheingold & Golomb, P.C.

THE EFFECTS OF TORT REFORMS ON THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS: A SUMMARY OF RESEARCH RESULTS

Testimony Submitted by Patricia M. Danzon
To the Committee on the Judiciary, United States Senate

March 26, 1986

Mr. Chairman and members of the Committee, my name is Patricia Danzon. I am Associate Professor of Health Care Systems & Insurance at The Wharton School, The University of Pennsylvania, and a consultant to The Institute for Civil Justice at The Rand Corporation. Rand is a private, nonprofit corporation that conducts public policy research. The Institute for Civil Justice was established in 1979 within Rand and is supported primarily by corporate and foundation grants.

My testimony concerns the results of studies I have conducted for the Institute on the frequency and severity of medical malpractice claims.[1] In the late 1960s, the frequency of claims per physician and claim severity (average payment per paid claim, including jury verdicts and out-of-court settlements) began to increase at unprecedented rates, culminating in the medical malpractice crisis of the mid-1970s. In response to that crisis, legislatures in almost every state enacted tort reforms intended to curb the rise in claims, in addition to other changes designed to assure the availability of malpractice insurance.

Between 1975 and 1978, claim frequency per physician slowed or even decreased in many states, but since 1978, claim frequency has resumed an upward trend. The St. Paul Fire and Marine Insurance Company, which has been a leading writer of malpractice insurance for many years, reported a 55 percent increase in claim frequency between 1980 and 1984 -- from 10.5 claims per 100 physicians in 1980 to 16.3 in 1984.[2] Claim severity increased faster than the rate of inflation throughout the 1970s, and this trend appears to have continued into the 1980s. On average, over the decade 1975-1984, claim severity increased at almost twice the rate of increase in the Consumer Price Index (CPI).[3] The St. Paul reports that claim severity increased 95 percent during the five-year period 1979-1983, from $27,406 in 1979 to $53,482 in 1983.[4] The average malpractice jury award is reported to have risen from $404,726 in 1980 to $954,858 in 1984.[5] This upward trend in claim costs, together with the recent spate of large malpractice premium increases, has revived interest in tort reform, and hence, in the impact of the reforms enacted after the 1975 crisis. Today I shall summarize the results of three studies that provide some evidence on the impact of these reforms. Each of these studies uses data from a different time period; the findings show slight differences, but are broadly consistent.

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[1] Danzon and Lillard, 1982a; Danzon and Lillard, 1982b; Danzon, 1982; Danzon, forthcoming. Danzon, 1982, was partially supported by the Health Care Financing Administration, U.S. Department of Health and Human Services. Danzon, forthcoming, was partially supported by the Urban Institute. The views expressed here are mine and are not necessarily endorsed by my research sponsors.

[2] *Physicians' and Surgeons' Update*, 1985, The St. Paul Fire and Marine Insurance Company, St. Paul, Minnesota.

In the first study, my colleague, Lee Lillard, and I examined the disposition of some 6,000 individual medical malpractice claims closed in either 1974 or 1976.[6] The former were disposed before most states had moved to institute reforms. The latter begin to reflect the effects of legislation enacted in response to the perceived malpractice crisis. Assessing these effects is difficult for several reasons.

First, the precise form of a given reform measure varied from state to state. For example, relaxing the collateral source rule could involve simply making evidence of collateral compensation payments admissible in court, or it could authorize deductions from the court award to avoid double payment to the plaintiff.

Second, identifying whether particular statutes could have affected claims in the data base is unavoidably imprecise. Our analysis considered only those statutes that were enacted prior to the closing date of claims in the 1976 sample. Some statutes, however, did not become effective until several months after they were enacted; claims in or near trial may have been exempted from recent changes in law; and there may have been further delays before changes in court decisions fed back into changes in out-of-court settlements.

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[3] Danzon, forthcoming.

[4] *Ibid.*

[5] Jury Verdict Research, Inc. cited in n.2 *supra*.

[6] Danzon and Lillard, 1982a; Danzon and Lillard, 1982b.

Third, it was not possible for us to control for all of the changes being made simultaneously along with other unmeasured changes (e.g., alterations in judge-made tort law or in jury attitudes).

For all of these reasons, the effects realized in the period immediately following enactment -- the period captured by the 1976 data file -- may or may not be reliable guides to the long-term effects of each measure. Consequently, the estimates of the effects reported below were not viewed as definitive, but as rough, preliminary indicators of their apparent immediate impact. They were derived by comparing the change in awards between 1974 and 1976 in states which enacted a particular reform during that period and in states which did not.[7] Technical difficulties sometimes made it impossible to separate closely associated measures; in those cases, we grouped them together and arbitrarily assumed that they had equal impact. The resulting estimates should be regarded as particularly tentative.

When a state moved to cap verdicts, or to eliminate specific dollar requests by plaintiffs (i.e., bar the *ad damnum* clause), or to permit payments of awards for future losses in periodic installments, the seeming effect of any one of these changes was to:

- Reduce the average shadow verdict by 30 percent.
- Cut the average settlement by 25 percent.
- Raise the portion of cases dropped from 43 to 48 percent.
- Reduce the share of cases going to verdict from 5.1 to 4.6 percent.

The analysis does not permit an accurate estimate of the cumulative effect of these measures, and the assumption that all are of equal weight is probably incorrect. Evidence from the latest studies suggest that caps on awards have greater effect than periodic payments or limits on the *ad damnum*.

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[7] This controls for the fact that states with relatively high awards in 1974 were more likely to enact changes. Assuming no such changes, they could be expected to have high awards in 1976. If we simply compared the level of awards in 1976 in states which did and did not enact changes, we would underestimate the effects of the changes.

Relaxation of the ban on evidence of collateral sources of compensation for the injury seemed to reduce shadow verdicts by 18 percent, but the statistical significance of this finding was quite low.

Imposition of limits on contingent fees charged by plaintiffs' attorneys seemed to:

- Cut the average settlement by nine percent.
- Raise the portion of cases dropped from 43 to 48 percent.
- Reduce the share of cases going to verdict from 6.1 to 4.6 percent.[*]

All of these results suggest that the changes enacted in the tort law during the crisis period had substantial effects, and that these effects were in the directions probably expected by the lawmakers who adopted them. It is also true that the frequency of claims and the explosion of insurance premiums -- factors largely responsible for the sense of crisis -- abated during the years after 1976. But we emphasize that this analysis does *not* establish any necessary connection between these events: Many factors other than changes in tort law may have worked toward relieving the crisis. The evidence supports the general proposition, however, that these changes had important downward effects on settlements, verdicts, and the number of cases pressed to judgment, while tending to increase the number of claims that were dropped without payment.

In a second study, I used state-by-state data on the average number of claims closed per capita and average severity per paid claim for 1970 and 1975-1978. Information on individual claims was not available. These data were used to analyze the contribution of medical factors, demographic characteristics, and legal factors -- including tort reforms -- to the differences among states and trends over time in claim frequency and severity.

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[*] The estimate that 6.1 percent of cases would have gone to verdict in states which limited contingent fees, compared with 5.1 percent in states enacting measures to limit awards, shows that limits on contingent fees were adopted in states with relatively high litigation rates.

The study concluded that the increase in claims over time and the persistent diversity in experience among states could only partly be explained by such factors as the increase in the number and complexity of medical treatments and concomitant increases in exposure to the risk of iatrogenic injury.[9] The pro-plaintiff trend in common law during the 1950s and 1960s also appears to have contributed significantly to the rise in claim frequency and severity. The other major factor contributing to the diversity among states was urbanization; however, we could not identify the specific characteristics of urban environments that generated higher frequency and severity. Differences in the number of attorneys per capita, the cost of medical services, per capita income, and unemployment rates did not appear to play significant roles.

This early analysis found mixed early effects of the tort reforms enacted in response to the 1975 crisis. Limitations on the plaintiff's recovery (caps on awards) and mandatory offset of collateral benefits appeared, by 1978, to have significantly slowed the growth in claim severity in states that enacted such changes. However, none of the other changes, such as pretrial screening panels or shorter statutes of limitations showed any impact on frequency or severity. Moreover, none of the reforms could explain, in a statistical sense, the lull in growth of claim frequency that occurred between 1975 and 1978. However, this early analysis, using data on claims closed through 1978, obviously did not purport to measure the long-run impact of the tort reforms enacted since 1975. In particular, any impact of shorter statutes of limitations on the "long tail" of claims would not then be evident. As in the earlier study of individual claims closed in 1976, even the estimates of the apparent short-run effects might have been contaminated by other unmeasured factors related to the crisis, such as changes in public attitudes, which might prove short-lived.

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[9] Danzon, 1982.

In order to update these early estimates, I have just completed an analysis of the impact of the tort reforms and other factors on trends in malpractice claim frequency and severity, using claim experience over the full decade 1975-1984.[18] The length of time since the enactment of the 1974-1977 tort reforms should now, in principle, be long enough to estimate their long-run impact. However, in practice, there are several difficulties. First, the reforms have been suject to legal challenge in many states, and final rulings either upholding or denying their constitutionality have been long delayed. For example, the California cap on awards for pain and suffering was not finally upheld in state court until early 1985 and a U.S. Supreme Court appeal failed only in October 1985. To the extent that the disposition of claims over the last decade has been influenced by uncertainty as to the ultimate outcome of these legal challenges, it may still be too early to estimate full long-run effects of those that have been upheld.

A second practical difficulty in estimating the impact of tort reforms is lack of a consistent, comprehensive data base. The medical malpractice insurance market has undergone substantial changes since 1975 in the identity of carriers and types of coverages. Several major stock insurers have withdrawn, to be replaced by physician-owned mutuals and hospital "captives" and by joint underwriting associations (JUAs). A substantial fraction of the market has also changed from an "occurrence" policy (which covers all claims arising out of medical incidents occurring in the policy year regardless of the date of claim filing) to "claims-made" coverage (which covers only claims filed in the policy year regardless of the date of injury, provided that the physician was covered by a claims-made policy with that company at the time of the injury). Although these changes in liability insurance markets are not expected to affect the behavior of patients and courts with regard to filing and disposing of claims, the large number of insurers who have had a significant market share for at least some fraction of the period under study makes collection of a comprehensive data base on claim experience very costly. The switch from occurrence to claims-made coverage further complicates the estimation of trends, particularly for claim frequency, because the number of claims reported tends to be low in the early years of claims-made coverage, rising as the policy "matures" -- even with no change in the underlying frequency of claims filed.

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[18] Danzon, forthcoming.

My earlier analysis of 1970's malpractice claim trends drew on a virtual census of all claims closed during 1975 through 1978, collected in a special survey by the National Association of Insurance Commissioners (NAIC). Since 1978, there has been no national compilation of malpractice claims. Data for this recent study were requested from most of the insurers with a significant market share at any time from 1975 through 1984. Several of the largest stock insurers and physician-owned companies, covering roughly 100,000 physicians, provided data in the format and detail requested. Forty-nine states are represented for at least some years. However, it remains possible that the data base may not be fully representative of the situation nationwide.[11]

In attempting to measure the effects of various factors, including tort reform, on malpractice claims frequency and severity, I statistically compared the average experience of physicians in different states and at different points in time over the ten years, 1975-1984. As in the second study discussed above, the units of observation are not individual claims, but individual states in each year. The variables to be explained are claim frequency per 100 physicians and average severity per paid claim, by state.

To estimate the impact of a particular tort reform, one cannot simply compare the experience of State X before and after enactment because other factors may have changed over the same timespan. Similarly, one cannot simply compare, at a particular point in time, states that have enacted a particular reform and states that have not because other factors may contribute to any observed differences between states. For example, assume that State A, which enacted a cap on awards, had 20 percent higher claim severity in 1984 than State B in 1984. One should not infer that the cap had no effect because it may be that claim severity would have been 50 percent higher in A than in B had the cap not been enacted. Thus, to estimate the net impact of the cap -- or any other factor -- statistical methods are used to attempt to "control" for other factors.

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[11] For example, data published by the American Medical Association show significant differences in claim frequency for 1983, by type of insurer. Physician-owned companies linked to medical societies reported 24 claims per 100 insured physicians in that year, compared with only 10 per 100 insured physicians for commercial companies and 11 per 100 for independent provider-owned insurers. AMA, 1984, p. 10. These differences could reflect such factors as differences in states in which the companies do business, differences in underwriting stringency, and simple differences in claim reporting practices.

The number of factors that can be controlled for depends on the number of independent observations in the sample, which determines the "degrees of freedom," and on the subset of the observations that have the characteristic of interest. In this data base, there are observations on over 45 states in each of 10 years, but the effective degrees of freedom are less than 450 (45 times 10) to the extent that experience in successive years in any state is not fully independent of experience in the same state in prior years. This complicates measurement of statistical significance.[12] Further, it is not possible to measure the effect of each variant of each reform -- for example, a cap on pain and suffering at $250,000, at $100,000, and so on -- because the number of observations on each variant is too small. For most reforms, the average impact for each type of change has therefore been estimated. Two exceptions are that separate estimates were made for the effects of mandatory and discretionary collateral source offset and for different types of legislation regarding screening panels.

With these caveats, the evidence from this analysis suggests that the last round of tort reforms affected the frequency and severity of malpractice claims over the decade 1975-1984 in a manner broadly consistent with theory and previous evidence. Although claim frequency and severity have continued to rise despite reforms, this does not mean that the tort changes have had no effect. States that enacted shorter statutes of limitations and set outer limits on discovery rules have had less growth in claim frequency than states with statutes more lenient to plaintiffs. On average, cutting one year off the statute of limitations for adults appears to have reduced claim frequency by eight percent; the effect would presumably be greater for reduction from, say, four to three years than from ten to nine years.

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[12] This is discussed further in Danzon, forthcoming.

Statutes permitting or mandating the offset of collateral benefits have apparently reduced malpractice claim severity by 11-18 percent and claim frequency by 14 percent relative to comparable states without collateral source offset. The feedback from a reduction in severity to a reduction in frequency is not surprising, since collateral source offset reduces the potential recovery for a large number of claims, so reduces incentives to file.

Caps on awards have reduced severity by 23 percent. This is the average impact of the various forms of caps over the period 1975-1984. If the dollar thresholds are not revised periodically to keep pace with inflation, the future effect will presumably be greater, unless juries find ways of implicitly circumventing the limits by increased allowances for uncapped components of the award.

Arbitration statutes appear to have increased claim frequency and reduced average severity. Disaggregated (i.e., individual claim) data are necessary to determine whether the reduction in observed average severity results from a reduction in awards per case or simply reflects the filing of more small claims. The net effect appears to be an increase in total claim costs but compensation to more patients.

None of the other reforms analyzed, including screening panels and limits on contingent fees, appear to have had any systematic impact on claim frequency or severity.

Among the other factors affecting claims, urbanization remains a highly significant factor that explains much of the observed difference among states in claim frequency and severity. Per capita income, the unemployment rate, and the number of attorneys per capita have no statistically significant effects after controlling for urbanization. The surgery rate in a state increases claim frequency; the ratio of surgeons to medical specialists increases claim severity.

In summary, these three studies suggest that caps on awards and collateral source offset have significantly reduced claim severity; collateral source offset and shorter statutes of repose have signficiantly reduced claim frequency. These studies did not attempt to measure the effect of tort reforms on malpractice insurance premiums. That would depend not only on the effect on expected claim cost, but also on the effect on investment income and on predictability of losses. Reforms which reduce uncertainty of tort losses should reduce the volatility of price and availability of malpractice insurance.

Finally, from a public policy perspective, the goal of tort reform should not be simply to reduce the costs of claims and of malpractice insurance. Reforms should be evaluated in the broader context of the fundamental purposes of the tort system, which are deterrence of medical negligence and efficient compensation of its victims. I believe that the tort system can be made cost effective in performing these dual roles, as discussed elsewhere.[13]

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[13] Danzon, 1985.

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2. Patricia Munch Danzon, *The Frequency and Severity of Medical Malpractice Claims*. Santa Monica CA: The Rand Corporation, R-2870-ICJ/HCFA, 1982.

3. Patricia Munch Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*. Santa Monica CA: The Rand Corporation, forthcoming.

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Senator **Kerry**. Thank you all very, very much. The hearing now stands adjourned.

[Whereupon, at 1 o'clock p.m., the committee was adjourned.]

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